



Claim Medical Review Submission Form

All information must be submitted to Health First Network for payment consideration. Medical Reviews will not be accepted by email or fax. Medical Reviews must be submitted in writing to the following address:

**Health First Network  
PO BOX 10786  
Pensacola FL 32524-0786**

All received dates for appeals are based on the EOB date of the original claim

**Please select the insurance applicable to the Medical Review submission:**

- Wellcare (must be received w/in 60 days from date of original denial)
- Coventry/Vista (Par providers -45 days from date of original denial, Non par -1yr)
- Coventry Healthy Kids (Par providers – 45 days from date of original denial, Non par 1 yr)
- HealthSpring(180 days from date of original denial)

**Provider of Service** (Physician or Facility) \_\_\_\_\_

**Address** (number, city, state, zip) \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_

**Contact Person** \_\_\_\_\_ **Date** \_\_\_\_\_



**Member Name** \_\_\_\_\_ **Member ID** \_\_\_\_\_

**Original Claim Number** \_\_\_\_\_ **Date of Service** \_\_\_\_\_

**Type of Medical Review:**

- Modifier Issue
- Unlisted Code
- Authorization Issue
- Requested Documentation attached
- Other

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Please provide a detailed explanation of the Medical Review. All Medical reviews must be accompanied by pertinent clinical documentation.