PROVIDER CLAIM APPEAL FORM

Date: _____ Submitter Name: _____

Provider Name: _____ Provider NPI/TIN #: _____

Claim Appeal Information

Member Name: _____ Member ID #: _____

Date Claim Denied: _____ Date Submitted: _____

CPT/HCPCS Denied: _____

Reason/Issue for Appeal

☐ Claim denied – no authorization

☐ No authorization was required.

☐ Authorization obtained # _____

☐ Claim denied – not filed timely:

- Please attach proof of timely filing.
- Please attach explanation of why claim wasn't submitted timely.

☐ Other:

- Please attach an explanation.

Submit Completed Form(s) and Attachments to:

Secure Email: claims@gobhi.org

Mail: Greater Oregon Behavioral Health, Inc
Attn: Claims Department
401 East 3rd St
The Dalles, OR 97058

Fax: 541-298-7996