Clover Health

Appeal Form

If you are an out-of-network provider disputing a $0 paid claim, please use this form to submit an appeal. If you believe your claim was underpaid/overpaid, please use the Payment Dispute Form.

Provider Information	Contact Information
Provider Name:	Name:
Provider NPI:	Address:
Tax ID:	Phone #: ( )
Group Name:	Fax #: ( )

Patient Information ☐ HMO ☐ PPO	Attachments
Patient Name:	Remittance Advice ☐ Medical Records ☐
Member ID:	WOL **(REQUIRED)** ☐ AOR ☐
	Supporting Documentation ☐

Claim Information	
Claim Number:	Date of Service: _____ /_____ /_____
Date of Determination: _____ /_____ /_____	
*Please provide good cause if appeal is filed after 60 days from date of determination.	

Reason for Appeal (Please select one.)			
Denial Code(s): ☐ _____	Whole Claim: ☐	CPT Codes: ☐	_____
Other (Please provide a description.) ☐			

Description (Please provide additional information not addressed above.)

Provider Experience Line: 1-877-853-8019 or Appeals Fax: 1-732-412-9706