PROVIDER CLAIMS APPEAL FORM

Complete this form and return to Parkland Community Health Plan for processing your appeal.

Provider Name: ______________________ Provider NPI: _____________________
Member Name: ______________________ Member ID Number: _____________________
Member DOB: ______________________ Claim Number: _____________________
Date of Service: ______________________ Amount Billed: _____________________

Please describe in detail, the nature of your appeal and include the date of service. Please print or write legibly. Attach additional documents if necessary.

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Attach all documentation and return to:

Parkland Community Health Plan
P.O. BOX 569150
DALLAS, TX 75356-9150

Person Requesting Adjustment:___________________
Phone Number:___________________
Date:___________________