ABS Automated Benefit Services
AUTOMATED BENEFIT SERVICES, INC.

Appeal Request Form

If you are a member submitting an appeal, please complete the information below and include any additional medical records or documentation to support your appeal. If you have a copy of the claim or the Explanation of Benefits (EOB) please include a copy with your submission.

If you are a provider submitting a claim on behalf of a member, please include a copy of the EOB, a copy of the claim and any/all medical records and/or documentation to support your request for the appeal.

Check appropriate box:

Processed Claim Appeal	*Prior Authorization Appeal*	*Retro Authorization Request*

Appeal is being filed by: Member ____ Physician ____ Facility ____ Other Representative ____

If other representative, please note relationship to member: _____

Appellant Contact Name	*Appellant Contact Phone Number*	*Appellant Contact Fax Number*

Please complete the following information:

Today's Date	*Group Name*	
Member's First Name	*Member's Last Name*	*Member's ID number*
Patient's First Name	*Patient's Last Name*	*Patient's Date of Birth*
Name of Provider	*Provider's TIN/NPI*	*Provider's Phone Number*

Claim Number	*Claim Date of Service*

CPT/HCPCS/Service Being Disputed
Explanation of your request (please submit additional pages if necessary)

Please fax your appeal to: (586) 238-4363
You may also mail your request to: Appeals Department, PO Box 321125, Detroit MI 48232

If you are a provider submitting an urgent request for a prior authorization denial, please mark urgent and include supporting documentation as to why the urgent review is necessary.

Urgent Pre-Service Appeal ☐

Revised March 2019