UF | Ped-I-Care
Department of Pediatrics
UNIVERSITY of FLORIDA

Claims Payment Appeal Form

Note: Appeals must be received within 60 days of notification of a denial or payment issue (i.e. within 60 days of the EOB date). Please be sure to include any documentation supporting your appeal.

Provider of Service (Physician or Facility) | Medicaid Number

Address (Number, City, State, Zip)

Telephone | Fax

Contact Person | Date

Claim Summary Information

Member Name | Member ID | DOB

Claim Number from EOB | Date of Service

Type of Appeal (Check all that apply): ☐ First Level Appeal ☐ Second Level Appeal

Reason for Appeal (Check all that apply): ☐ Payment Issue ☐ Timely Filing ☐ Authorization Issue

Notes: ☐ Requested Documentation Attached ☐ Other: _____

Please provide detailed explanation for appeal. Be sure to include all supporting documentation; i.e. copy of denial from EOB, copy of original claim, copy of electronic submission confirmation form for timely filing, pertinent clinical notes, etc. Attach additional sheets as necessary.

Mail or fax completed form and documentation to:

Ped-I-Care Claims Appeals
University of Florida ICS • 1699 SW 16th Avenue, Third Floor • Gainesville, FL 32608
Fax: (352) 294-8092