# Appeal/Reconsideration Request Form

**Select the Case Type**

Post-service (Claim) Appeal  Non-par (No Auth Denial) Appeal

2nd Level Appeal

**Select Plan:**

ArchCare Senior Life  ArchCare Community Life  ArchCare Advantage

**Today’s Date:** Click or tap to enter a date.

**Request Type:**

Auth Reconsideration Timely Filing Coordination of Benefits Eligibility

Corrected Claim NAMI Payment Dispute Missing Provider Data Other

**Claim Number:** Click or tap here to enter text.

**Service Start Date:** Click or tap to enter a date. **End Date:**Click or tap to enter a date.

**Patient Member ID:** Click or tap here to enter text.

**Provider Name:**Click or tap here to enter text.

**Provider NPI:** Click or tap here to enter text. Tax ID: Click or tap here to enter text.

**Provider Address:** Click or tap here to enter text.

**City:** Click or tap here to enter text. **State:** Click or tap here to enter text. **Zip:** Choose an item.

**Case Details**

**Issue Description:**Click or tap here to enter text.

**Submitter Information**

**Submitter Company Name:** Click or tap here to enter text.

**Submitter First Name:** Click or tap here to enter text. **Last Name:** Click or tap here to enter text.

**Submitter Email:** Click or tap here to enter text.

**Submitter Address for Correspondence:**

Same as above or

**Submitter Address:** Click or tap here to enter text.

**Sub City:** Click or tap here to enter text. **Sub State:** Click or tap here to enter text. **Sub Zip:** Choose an item.

**Please include medical records and/or attachments as appropriate.**

**Please mail to:**

**ArchCare Appeals**

**205 Lexington Avenue**

**2nd Floor**

**New York, NY 10016**