# 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**