

Provider Appeals Form

Pre-Appeal First Level Appeal

Provider Information

Provider Name: _____

Medicaid Contract ID*: _____ NPI**: _____

Contact Name: _____

Contact Telephone No.: _____

Recipient Information

Recipient Name: _____

Recipient ID No.: _____

Date of Service Related to this Appeal: _____

Service(s) or Procedure(s) Related to this Appeal: _____

Reason for Request (i.e., medical justification, timely filing, etc.)

*Formerly known as Alaska Medical Assistance Provider Number

** National Provider Identifier