Quad City Community HEALTHCARE

Provider Appeal Form

Please mail completed form along with documentation if required to:

Quad City Community Healthcare
246 West Third Street Suite 100
Davenport Iowa 52801-1931

For Provider Claim Inquiry By Telephone
Call Customer Service at:
563-322-8995 or 1-888-498-7224

Provider appeal is exclusively reserved for provider claim adjudication resolution when all other provider claim inquiry ahs been exhausted and not for the purpose of appealing a pre or post service member benefit or in behalf of a member for pre or post service claim resolution. A provider appeal must be submitted within 180 days of the date of remittance but not later than 365 days from the date of service.

Complete all information below and attach medical records or documentation to support the appeal including prior claim inquiry communications, remittance notification, claim forms and an other information to assist in your appeal. An incomplete form will result in the appeal returned to you. Only information submitted with this form will be considered in the appeal.

Provider Name	Date of Request
Tax ID	Individual NPI
Address	
Contact Name	Contact Phone

Member Name (Patient Name)	
9 character ID #	Group #

List all dates of service and claim numbers involved in your provider appeal:

	Date of Service	Claim # (First 12 digits only)	Billed Charge Amount
1			
2			
3			
4			
5			
6			

Describe your appeal (If necessary you may attach information on your letter head)

Reserved/Internal QCCH Routing

Rcvd: By: T: S B
Rv'd: By: Rec:
Snt: