zelis

Claim Appeal Submittal Form Bill Review

Complete all information requested below and fax or email **with a copy of complete medical records**, itemized bills and a copy of the HCFA-1500 or UB-04 to (908) 658-3511 or billreview.integrity@zelis.com.

Provider/Facility Name

TIN NPI

Claim Number Date of Service

Is the provider in the patient's network? Yes ☐ No ☐

Patient Name

DOB Date

Billed Charges

Total Allowed Total Noncovered

Noncovered Amount Reason

Contract Payment

DRG DRG With Outlier % of Billed

% of Medicare Per Diem Case Rate

Were services preauthorized and approved? Yes ☐ No ☐
If yes, please attach supporting documentation.

Principal Diagnosis Code Secondary Diagnosis Code

Admitting Diagnosis Code

Reason for Appeal

Contact Information of Submitted

Phone Fax