

The one Texans trust.

Provider Claim Appeal Request Form

In order to expedite the process of your request, this form is required. **Please complete all of the following information for each appeal; if not complete the correspondence will be returned to the provider for correction.**

Provider Name: _____ Contact Name: _____

Provider Address: _____ Contact Phone Number: _____

Member Name: _____ SWHP Member ID#: _____

SWHP Claim number: _____ Date Of Service: _____

Review Submission Date: _____

Choose the appeal below that best represents your request:

Claim Appeals
<input type="radio"/> Filing Limit
<input type="radio"/> Contract Rate or Payment Policy
<input type="radio"/> Data Entry Error
<input type="radio"/> COB
<input type="radio"/> Claim Check/Code Editing
<input type="radio"/> Other(specify)

**Attach any pertinent supporting documentation, surgical notes, office visit notes, pathology reports, and/or medical records.

Claim Appeals send to:

Scott and White Health Plan
Attn: Claims Review Dept.
P O Box 21800
Eagan, MN 55121-0800

**** Faxed claim requests are not accepted****

**** Mail only****

All Claim Appeals must be submitted within 45 days of the date of the adverse determination by SWHP to receive consideration.