Provider Claim Appeal Form

Instructions: The Provider Claim Appeal Form may be submitted for unsatisfactory responses to the processing, payment, and resubmission of a claim or a claim inquiry. Medi-Cal Rx Claim Appeal Team reviews each claim individually using the documents presented by the provider to render a fair decision. Please carefully read the enclosed instructions prior to completing and signing the Provider Claim Appeal Form. All required fields must be completed to process the Provider Claim Appeal.

Providers must print, sign, date, and mail the form as per the instructions in the *Form Submission* section. Explanations regarding form fields are located below the form in the *Explanation of Provider Claim Appeal Form* section. Incomplete forms will not be processed and will be returned to the provider.

*** Indicates Required Field**

PART 1 – Provider Information	
*Provider Name:	
*Service Address:	
*City:	
*State:	*ZIP Code:
*National Provider Identifier (NPI) Number:	
PART 2 – Claim Information	
*Claim Type: ☒ Pharmacy As provided by the *California Administrative Code, Title 22, Section 51015 (b-d)*, I am submitting an appeal of my claim as defined below. Enclosed are all pertinent documents corresponding to the appeal, including copies of the claim, Explanation of Benefits (EOB), Remittance Advice (RA), Claim Inquiry Form (CIF), Medicare Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN), and previous correspondence with Medi-Cal Rx.	
*Beneficiary Name:	
*Beneficiary Medi-Cal ID Number:	

*For each claim (up to eight claims per form) fill in all claim line information in the associated row below.

	Rx Number	Date of Service (MM/DD/YYYY)	NDC or Medical Supply Billing Code	EOB/RA Code	Number of Attachments
1					
2					
3					
4					
5					
6					
7					
8					

Total Attachments: _____

PART 3 – Appeal Reason

*Describe the **Appeal Reason** below and enclose all supporting documents, including a copy of the claim. Check all that apply. Refer to the *Claim Appeal Processes* section of the *Medi-Cal Rx Provider Manual* for additional information and guidelines regarding the appropriate items to be submitted with an appeal. If listing multiple claims on the Provider Claim Appeal Form, specify to which claim each reason applies.

☐ Eligibility (Proof of Eligibility attached)

☐ Crossover (EOMB attached)

☐ Adjustment Request (Refer to the *Supporting Documentation for Appeals* section of the *Medi-Cal Rx Provider Manual* for required supporting documentation)

☐ Other Reason (please describe below):

PART 4 – Provider Certification

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on this form. The signature of the provider or the authorized representative binds the provider to statements and conditions contained in this form.

***Signature of Provider or Authorized Representative** *(Original Signature Required; Use Blue Ink)*:**

_____

***Print Name:**

_____

***Date:**

_____

Form Submission

Print, sign, date, and mail this completed form to the address below. For assistance in completing this form, please call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

Medi-Cal Rx Customer Service Center
ATTN: Provider Claim Appeals
P.O. Box 610
Rancho Cordova, CA 95741-0610

Explanation of Provider Claim Appeal Form

A claim appeal is the final step in the administrative process and a method for Medi-Cal Rx providers with a dispute to resolve problems related to their claims. Resubmission, underpayment, and overpayment requests for the same beneficiary may be combined on one form. However, each claim appeal should include only one beneficiary.

Refer to the *Claim Appeal Processes* and *Provider Claim Appeal Form* sections in the *Medi-Cal Rx Provider Manual* at https://medi-calrx.dhcs.ca.gov/provider/forms for claim appeal submission requirements.

Explanation of Form Fields

All required form fields *must* be completed to process the claim appeal. If fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected Provider Claim Appeal Form and all supporting documentation.

Provider Information

Provider Name: Enter the provider name.

Service Address, City, State, ZIP Code: Enter the service address for the provider.

National Provider Identifier (NPI) Number: Enter the provider's 10-digit NPI number.

Claim Information

Claim Type: Defaulted to Pharmacy. For claim appeal information for other claim types (e.g., Long Term Care, Inpatient, Outpatient, Medical), visit https://www.medi-cal.ca.gov/.

Beneficiary Name: Enter the beneficiary's first and last name.

Beneficiary Medi-Cal ID Number: Enter the beneficiary ID number that appears on the Remittance Advice (RA) showing adjudication of that claim.

Rx Number: Enter the Rx number.

Date of Service: Enter the date of service of the claim in MM/DD/YYYY format.

NDC or Medical Supply Billing Code: Enter the National Drug Code (NDC) or 11-digit NDC-like medical supply billing code. When submitting an appeal for a compound drug claim, enter zero ("0") in place of listing the NDCs, and include each ingredient NDC with the attachment(s).

EOB/RA Code: Enter the Explanation of Benefits (EOB)/Remittance Advice (RA) Code, if applicable.

Number of Attachments: Enter the number of attachments associated with this request.

Total Attachments: Enter the total number of attachments for all requests included on the form.

Appeal Reason

Appeal Reason: Choose the appropriate Appeal Reason and ensure any required supporting documentation is included with your request.

Provider Certification

Signature of Provider or Authorized Representative: The signature of the provider or the provider's authorized representative. An original signature is required; use blue ink.

Print Name: Print the name of the person signing the form.

Date: The date on which the form is signed.