Provider Appeal Form

Physicians Health Plan

Please submit this form with documentation/medical records supporting your appeal. Once PHP receives this form, you will get an official letter of confirmation of the initiated appeal process.

Please choose your type of appeal:

CLEAR FORM

- ☐ **Claim Related**
- ☐ **Denied Authorization**
- ☐ **Payment Dispute**
  Disputing reimbursed amount
- ☐ **Increased Payment Request**
  Requesting additional reimbursement for complicated procedure.

NOTE: *To review your request, we require both medical records and an explanation from the provider describing the complicated procedure.*

Member Name:	**Provider Name:**
Member Number:	**Provider Number:**
Date of Service:	**Contact Name:**
Claim Number:	**Contact Phone Number:** **Contact Fax Number:**
Claimed Amount:	**Contact Address:**

Please provide a detailed description of your appeal:

Please Send Appeal To:

PHYSICIANS HEALTH PLAN
ATTN: PROVIDER APPEALS
PO BOX 30377
LANSING, MI 48909-7877

FAX: 517.364.8517 , MONDAY-FRIDAY, 8 A.M. to 5 P.M., EST