Provider Appeal Form

Please submit this form with documentation 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:

☐ **Claim Related**

☐ **Denied Authorization**

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

Please provide a detailed description of your appeal:

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Please Send Appeal To:

Physicians Health Plan
Attention: Customer Service Provider Appeals
PO Box 30377
Lansing, MI 48909
Or Fax to: (517) 364-8411