Provider Appeal Form

Send completed form to: shawdprovider@selecthealth.org. Access this form at: selecthealth.org/providers/forms.

Date

Provider Name | Office Contact

Address | City, State, ZIP

Area Code/Telephone | Email

Patient Name | Subscriber ID

Date of Service | Billed Amount

Select Health® Claim # | Auth #

What is the reason for the appeal?

What would you like us to do?

Additional notes and/or documentation is required for all appeals to be reviewed. Please select how supplied:

- ☐ Notes attached
- ☐ Notes in iCentra

NOTE: Do not submit an HCFA-1500 or UB-04 form with your appeal form. This may result in your appeal being logged as a claim rather than an appeal and can result in a duplicate claim denial.