Provider Appeal Form

Send completed form to: shawdprovider@selectheath.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.

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