**PROVIDER CLAIM APPEAL FORM**

Use this form as part of the Nebraska Total Care Appeal process to address the decision made during the request for review process.

NOTE: All claim appeals must be received within 60 calendar days from the date of the Medicaid Remittance. ***This form should be utilized if a claim has been processed and a Medicaid Remittance Advice issued from Nebraska Total Care – Do not use for first time claims.***

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|---|---|
| Member's Name: | Member's Medicaid Number: |
| Date(s) of Service: | Control/Claim Number(s): |
| Medicaid Remittance Date: | Billed Charge(s): |
| Provider Name: | Provider TIN Number: |
| Medicaid Provider Number: | Provider Contact Number: |
| Contact Name: | Contact Address: |

All fields below are required information. Failure to complete the form may result in a delay of your request.

Reason for Claim Appeal Request:

An Appeal is a formal written request to Nebraska Total Care for review on a reconsideration that is upheld. Appeals must include medical records or medical information to support why a provider feels that claim should process for payment. Please include EOB if possible to support the claim detail you are inquiring about.

Nebraska Total Care
Attn: Claims Appeals
PO Box 5060
Farmington, MO 63640-5060

Nebraska Total Care will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision) or overturn out original decision (if we overturn our original decision, we will send you a letter stating our decision and any additional payment due will appear on the provider remittance.)

This form may be photocopied