# COLORADO ACCESS CLAIM APPEAL FORM

All fields are required. If information is missing, the appeal will not be processed and will be returned to the address listed on the form below.

- ☐ CHP+ offered by Colorado Access
- ☐ ACCBDH (Behavioral Health Denver Health)
- ☐ ACCB3 (Behavioral Health Region 3)
- ☐ ACCB5 (Behavioral Health Region 5)

**COMPLETE A SEPARATE REQUEST FOR EACH RECIPIENT AND/OR CLAIM.** *INCLUDE THE FOLLOWING:*

1. A copy of the claim in question
2. A copy of the EOP showing the recent payment
3. Medicare/Third Party Liability - a copy of the Explanation of Benefits
4. Other documentation as necessary
5. If you are making this appeal on the member's behalf, include a Release of Information form

| | | |
|---|---|---|
| Provider Name: | | |
| Billing Address: | | |
| City: | State: | Zip: |
| Contact Name: | Phone: | |

**ALL FIELDS BELOW MUST BE COMPLETED**

| | | |
|---|---|---|
| Member ID: | Date of Service: | |
| Member Name: | EOP Date: | Billed Amount: |
| Billing Provider TIN: | Claim Number: | |

**DESCRIBE REQUEST (YOUR DESCRIPTION MUST INCLUDE ANY PROCEDURE CODES/UNITS/AMOUNTS, ETC.)**

Date: By (Provider Authorized Signature):

**Mail request to:** Colorado Access Appeals
PO Box 17189
Denver, CO 80217



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