Evry Healthcare Inc.
URA License # 2447557
PO Box 571208
Dallas, TX 75357

# REQUEST FOR AN APPEAL

Today's Date: _____

Authorization ID Being Appealed: _____

Name of Party Requesting the Appeal: _____
Print (Last Name) (First Name) (Middle Initial)

Relationship to Patient: _____
(Self, Mother, Father, Physician, Attorney, Other)

Reason for Requested Appeal (continue on back if necessary):

## Provider of Record:

First, Last Name: _____

Street: _____

City: _____, State: _____, Zip Code: _____

Contact Phone Number: _____ - _____ Fax Number: _____ - _____ (if applicable)
(area code) (number) (area code) (number)

PROVIDER OF RECORD – The physician or other health care provider that has primary responsibility for the care, treatment and services rendered to the patient and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

## Patient:

Group Number: _____ Member ID Number: _____
(Numbers are typically on the patient's ID card)

Patient's Date of Birth: (month) _____ (day) _____ (year) _____ Gender: _____ ID Number: _____

Name: _____ Street: _____

City: _____, State: _____, Zip Code: _____

Phone Number: _____ - _____ Fax Number: _____ - _____ (if applicable)
(area code) (number) (area code) (number)

## Person Requesting the Appeal:

Name: _____ If a Provider, Federal Tax Identification Number: _____

Street: _____ City: _____ Zip Code: _____

Phone Number: _____ - _____ Fax Number: _____ - _____ (if applicable)
(area code) (number) (area code) (number)

Signed: _____ Date: _____ _____ _____
(month) (day) (year)

**Return this form to:** Evry Health, PO Box 571208, Dallas, TX, 75357. Phone: 855-579-3879, Fax: 325-603-0541 or email grievancesandappeals@evryhealth.com. You do not have to complete this form to have your appeal reviewed, but the form will help us with the appeal. If you have any questions concerning this process, please feel free to call Evry Health for information.
***This form is for clinical appeals only. If you are disputing a claim, please use the Provider Dispute form.**