LOYOLA PHYSICIAN PARTNERS
CLAIM APPEAL FORM

COMPLETE THIS FORM ENTIRELY AND FAX TO 708-469-4621 or MAIL TO:
LOYOLA PHYSICIAN PARTNERS
PO BOX 9006
OAK BROOK, IL 60522-9006

Please remember to include all additional supporting documentation.

Date: _____

Provider and/or Practice Name: _____

Tax ID: _____

Name and Phone Number of Contact Person if additional information is needed:

_____ _____

Name Telephone

Fax Number for Response Transmittal: _____

Please provide the following information and attach a copy of the EOB, the claim and any supporting documentation with a copy of this form:

Patient Name: _____

Patient IPA: _____

Patient ID: _____

Patient Date of Birth: _____

Date of Service: _____

Original Claim Number: _____

CPT/HCPCS Code: _____

Appeal Reason:

- ☐ Disagree with duplicate denial
- ☐ Disagree with denial of no authorization. Attach copy of referral or authorization
- ☐ Disagree with timely filing denial. Attached proof of timely filing
- ☐ Disagree with payment amount. Specify why you disagree with payment amount:

_____

_____

- ☐ Other (specify below):

_____

_____