



# Curative Provider Appeal Request Form

## Instructions for Submitting a Curative Provider Appeal Request

This form is intended for use by providers submitting a formal appeal on behalf of the member for claims that have been denied or reduced based on clinical or utilization review decisions. These may include denials related to medical necessity, lack of prior authorization, incorrect level of care, or recoupment actions taken by Curative.

**Please do not use this form for administrative issues** such as duplicate claims, coding errors, or timely filing disputes. Those should be submitted using the Curative Provider Reconsideration Request Form.

Appeals must be submitted within 90 calendar days of the date listed on the Explanation of Payment (EOP) or denial notice.

## Instructions for Submission

Please submit this completed form along with supporting documentation via:

### PREFERRED METHOD

EMAIL: [providercustomerservice@curative.com](mailto:providercustomerservice@curative.com)

Please enter in Subject line: *Claim Appeal [your Claim Number]*

Curative Health Plan  
Attn: Provider Appeals  
PO BOX 1786  
Austin, TX 78767

If your request does not meet the criteria for an appeal, it may be rejected and returned with instructions to submit through the correct process.

## Section 1: Provider Information

Provider Name: \_\_\_\_\_

Group/Practice Name: \_\_\_\_\_

Tax ID (TIN): \_\_\_\_\_ Ind. NPI: \_\_\_\_\_

Practice/Facility NPI \_\_\_\_\_ Phone Number: \_\_\_\_\_



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Fax Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Section 2: Member and Claim Information (One Claim Per Appeal)**

Member Name: \_\_\_\_\_ Curative Member ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Claim Number(s): \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_ Total Billed Amount: \_\_\_\_\_

Total Paid Amount: \_\_\_\_\_ Expected Allowed Amount: \_\_\_\_\_

**Section 3: Appeal Type**

- Medical Necessity Denial (Non-Covered Services)
- Authorization Denial (authorization not obtained)
- Other: \_\_\_\_\_

**Section 4: Reason for Appeal and Supporting Documentation**

Explain the reason for the appeal and include supporting documentation (medical records, clinical notes, Explanation of Payment (EOP) or denial notice, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section 5: Provider Certification**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Title: \_\_\_\_\_