Formal Claim Appeal Request

Purpose: Use this form to request a formal claim appeal. Do **not** use this form to submit adjustments/voids, to make corrections to claims or to resubmit a denied claim.

Mail this request to: Hewlett Packard Enterprise, Attn.: Claim Appeals, P.O. Box 30042, Reno NV 89520-3042.

Or email this request to: ProviderClaimAppeals@hpe.com. To submit via email, scan this form and all supporting documents, including the original signed claim, and attach all items to one email. Please send the documents using secure email and write "Claim Appeal" in the subject line. Note: If this claim appeal is submitted via email, all future correspondence regarding this appeal will be done via email.

For questions regarding this form, call **(877) 638-3472**

DATE: _____/_____/_____

PROVIDER INFORMATION
Provider Name:
Provider NPI/API:
Name of person to be contacted regarding the appeal:
Contact person phone number:
CLAIM INFORMATION
Internal control number (ICN) (*16 digits*):
REASON FOR THE CLAIM APPEAL *(be specific)*
ATTACHMENTS
Please check the attachments you are including with this Formal Claim Appeal Request:
☐ Documentation to support the appeal request, e.g., physician's notes, medical records, etc.
☐ An original signed paper claim that may be used for processing should the appeal be approved. The billing provider or authorized representative must sign and date the claim. Original, rubber stamp and electronic signatures are accepted.