Provider Appeal Form

Fax completed form and any supporting documentation
to Itasca Medical Care (IMCare) at **218-327-5545**.
Call Member Services at **1-800-843-9536** (toll free) with questions.

Today's date _____

Provider name_____IMCare provider ID # _____

Address _____

City_____State_____Zip _____ Fax _____

Contact person_____Contact phone _____

Appeal Type (check one) ONE claim per Appeal Form.

☐ **Timely Filing** Please attach other insurance denials, EDI transmission and acceptance reports, Practice Management Software documentation, and any other documentation that would help when considering the Appeal, including claim follow up.

☐ **Coding Appeal** Please attach documentation supporting the coding Appeal on the denied claim.

☐ **Other Issue** For any other denied claim reason, please provide a detailed description of the claim involved and the reason for your Appeal.

Claim Information

Member name	Member ID #	Total $ amount
Date of service	Claim #	Overpaid/underpaid amount

Additional notes