Alabama Medicaid Agency

Request for Medical Utilization Redetermination

First Level of Appeal

This form is to be completed only when a claim has been denied for medical utilization. This form is not to be used if a denial of a claim has occurred for being outdated or for NCCI edits. This form is to be sent to the Fiscal Agent. Please print or type information in all areas.

Section A If additional space is needed for explaining your appeal (Section B) please add additional page(s) as needed.

Provider's Name:	Provider Number:
Recipient's Name:	Recipient's Medicaid Number:
Date of Service:	ICN:

I do not agree with the determination made on my EOB dated: __/__/____

Section B

Please explain in detail your reasoning that the denial should be over turned and the claim paid:

_____

_____

_____

_____

Section C

Provider or representative's signature:
Provider or representative's signature;
Provider or representative's name:
Address(Street, City, State and Zip):
Date: