

# Alabama Medicaid Agency

## Request for Medical Utilization Redetermination

### Second 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 This form is not to be used if a denial of a claim has occurred for being outdated or for NCCI edits.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 Director of Medical Services at the Alabama Medicaid Agency. Please print or type information in all areas. **If additional space is needed for explaining your appeal (Section B) please add additional page(s) as needed.**

#### Section A



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:

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#### Section C

<b><u>Provider or representative's signature:</u></b>
<b><u>Provider or representative's signature:</u></b>
<b><u>Provider or representative's name:</u></b>
<b><u>Address(Street, City, State and Zip):</u></b>
<b><u>Date:</u></b>