Provider Appeal Form

Date:	
Employer:	
Lifetime Benefit Solutions Alternate ID#: *(Can be found on your ID Card)*	
Patient's Name:	
Patient's Date of Birth (DOB): *(Example: mm/dd/yyyy)*	
Provider's Name:	
Provider's Address:	
Provider's Phone Number:	
Date of Service: *(Example: mm/dd/yyyy)*	
Date of Explanation of Benefits (EOB) OR Date of Denial Letter: *(Example: mm/dd/yyyy)*	
Summary of Appeal:	

Supporting documentation is very helpful when reviewing/resolving an appeal. If you have any records you feel are relevant to this case (i.e. emergency room notes, office visit notes, test results, proof of timely filing, etc.), please include them with this Appeal Form. You may then print this form and mail it with the documentation to:

Please print and return this form with the documentation to:

Lifetime Benefit Solutions
Supervisor of Provider Appeals
333 Butternut Drive
Syracuse, NY 13214

The cure for benefits as usual.

333 Butternut Drive | Syracuse, NY 13214 | 1-800-356-1029 | LifetimeBenefitSolutions.com