Analysis and Recovery Audit/Provider Request for Review Form

You may use this form to submit requests for multiple claim reviews.

Claim ID Number ____

Subscriber ID Number ____

Patient Name ____

Date of Service ____

Provider Name ____

Provider Address____

NPI Number or Provider ID ____

Contact Name ____

Phone Number ____________________________ Fax Number ___________________________

Email Address ____

Reason for request:

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Please include medical records or any other documentation to support your request.

Return this completed form and all supporting documentation via email or fax to:

Email: ARDappealUnivera@univerahealthcare.com

Fax: 315-798-4345