



PROVIDER APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant Leon to re-evaluate its original decision. Appeal requests must include claim numbers and supporting documentation (ie: copies of medical records). Review of claims does not guarantee a change in payment.

Provider name _____ Provider TIN _____

Contact _____ Phone _____

Fax _____ Leon Member ID Number _____

Address: _____

Member Name _____ Member ID _____

Claim Number _____ Date of Service _____

Reason for Appeal

Please mail this form to:
11501 SW 40 St

Leon Medical Center Health Plan
Miami, FL 33165

Physician's Signature: _____ Date: _____