REIMBURSEMENT ADVOCACY PROGRAM
PHYSICIAN REQUEST FOR CLAIMS ASSISTANCE
ASSIGNMENT FORM

TO: Santa Clara County Medical Association
Attention: Sandie Becker
700 Empey Way
San Jose, CA 95128
Ph: (408) 998-8850
Email: sandie@sccma.org Fax: (408) 289-1064

Before you file a request for assistance with the SCCMA, you must have already appealed your claim denial and received results with the carrier using the appropriate appeal guidelines.

Please be aware that a copy of this Request for Assistance and other documentation submitted by you may be provided to the insurance company. By signing and dating this form, you authorize the Santa Clara County Medical Association to contact the insurance company on your behalf.

FROM:

Doctor:____________________ Address:____________________

Contact name:____________________ Phone:____________________ Fax:____________________

Regarding Insurance Claim for:

Patient's Name____________________

Subscriber's Name____________________

Insurance Carrier____________________

Are you a contracted provider with this insurance? Y___ N___

Address/Phone____________________

Employer____________________

Date claim originally submitted____________________ Amt. of Charge/s____________________

Date claim appealed____________________(include appeal letter and response from carrier)

Briefly, describe your problem (use additional paper if needed):

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<u>IMPORTANT</u>! Attach copy of claim form/s, appeal letter and response, chart notes, lab results (if applicable), op report, insurance ID card, EOB and all follow-up correspondence to or from the insurance company.

Physician Signature____________________ Date____________________