

# AUC Appeal Request Form Instructions

Please also refer to the Appeals Best Practice on the AUC website at: <https://www.health.state.mn.us/facilities/ehealth/auc/index.html> for additional information.

## General Instructions:

The preferred method for completing this form is to type the information within the fields provided. If completed by hand, the information must be clearly printed within the fields provided using blue or black ink.

All fields on the AUC Appeal Request Form are required unless otherwise noted below.

A copy of the Appeal Request form and the attachment information should be retained for your records.

Fee-for-service Medicaid does not accept the appeals form that corresponds to this Best Practice due to regulatory requirements (citation: 42 CFR 447). In these cases, the provider must submit a new or replacement claim with the necessary documentation as an attachment.

Payer Name	Enter the name of the payer the appeal request is being made to.
Billing Provider Name	Enter your billing provider name. X12: Loop 2010AA, NM103, NM104 and NM105.
Billing Provider ID	Enter your NPI X12: NPI: Loop 2010AA, NM109 Atypical providers: Loop 2010BB, REF02.
Patient Account Number	Enter the patient's unique ID as assigned by the payer/group purchaser. For Version 5010 Use: Loop 2300, CLM01.
Patient Name	Enter the patient's name as reported on the claim. For Version <b>5010</b> Use: X12: Loop 2010CA, NM103, NM104, and NM105 or Loop 2010BA, NM103, NM104, and NM105. If both are populated within the claim, use Loop 2010CA, NM103, NM104, and NM105.
Patient ID#:	Enter the patient's unique identifier as assigned by the group purchaser. For Version 5010 Use: Loop 2010BA, NM109.
Date(s) of Service	Enter the date the service was provided in MMDDYY format.
Payer Claim Control Number	Use payer claim control number found in the 835 CLP07.
Property and Casualty or Workers Compensation Claim Number	This is also known as the event number. This field is only required for claims related to Property and Casualty or Workers Compensation.
Reason for Appeal Request	This is the reason the appeal is being requested.
Attachment(s)	Check appropriate box.
Contact Information	Enter the date the request is being completed, requester, contact phone number, contact email information and contact fax information. Include address where response should be sent.
Pages	Enter the total number of pages of your appeal information including the cover sheet.