Neighborhood Health Partnership
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 NHP to re-evaluate its original decision.

• An appeal request must include claim numbers and supporting documentation; *e.g.*, complete copy of the medical records and claim form.

• Review of a claim does not guarantee a change in payment disposition.

• Log on to *www.myNHP.com* for claim status or call Customer Service at 1-877-972-8845.

Date / / Customer Service Call ID (if applicable) _____

The Customer Service Call ID can be provided to you when you contact NHP Customer Service for assistance.

Provider name _____

Provider Number or TIN _____ Phone _____

Contact _____

Address_____

Member name _____

Member ID number _____

Claim number(s): _____

Date(s) of Service: _____

Reason for Appeal (attach supporting documentation)

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Please attach a copy of the inquiry determination form. Mail completed form and attachments to:

Neighborhood Health Partnership
PO Box 5210
Kingston, NY 12402-5210
Attention: Provider Appeals

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