Lovelace
Lovelace Health Plan &
Lovelace Insurance Company

*REQUEST FOR PROVIDER APPEAL**

Date: ___________

Contact Name: ____
Provider/Professional Name: ____
Address: ____
____
Phone Number: ____

Claim Information Re:
Lovelace Member: ____
Member ID#: LH: ____
Date of Service: ____

Appeal Request:
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You must attach a copy of:

- ***EOP showing the denial;***
- ***a copy of the original claim;***
- ***medical records; and/or***
- ***other supporting documentation***

SEND THIS FORM WITH REQUIRED DOCUMENTATION TO:
Lovelace Appeals
PO Box 27107
Albuquerque, NM 87125-7107
FAX: (505) 262-7307

Please allow (30) days from the time Lovelace Appeals Department receives your appeal to receive a decision. For appeal status please contact the Provider Response Team @ 262.3856 in Albuquerque or 800-808-7363, ext. 3856 statewide.

****Appeal*: A request for Lovelace to make an exception to business or industry practices, based on special circumstances.**

Rev 10/07