



Beam Benefits  
 ATTN: Appeals  
 PO Box 75372  
 Cincinnati, OH 45275

**APPEAL REQUEST FORM**

Please complete all fields of this form and mail to the address listed above. Incomplete forms will be returned. Please attach any EOBs (all pages) and further supporting documentation to this form. Beam will acknowledge receipt of your appeal within 15 working days and send a written resolution to your appeal within 20 business days.

Provider Name: \_\_\_\_\_ Provider Tax ID No. \_\_\_\_\_

Provider Address: \_\_\_\_\_ Provider License No. \_\_\_\_\_

\_\_\_\_\_ Provider NPI: \_\_\_\_\_

Appeal Type: Claim \_\_\_ Reimbursement/Overpayment \_\_\_ Processing Policy \_\_\_ Adjustment Request \_\_\_

Other \_\_\_\_\_

CLAIM INFORMATION Single \_\_\_ Multiple 'LIKE' Claims \_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ ID No. (10-digits): \_\_\_\_\_

Claim No. \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

Description (please attach additional pages, if needed):

\_\_\_\_\_

Contact Name, Title

\_\_\_\_\_

Email, Phone No.

\_\_\_\_\_

Provider Signature

\_\_\_\_\_

Date

