Beam Benefits
ATTN: Appeals
PO Box 7537
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