

### Insurance Appeal Note Taking Form

Keep this form with your copies of bills, treatment records, and other documents relating to this appeal. You may make copies of this form as needed.

Insurer \_\_\_\_\_ Insurer contact number: \_\_\_\_\_

ID # \_\_\_\_\_ Insurer contact name: \_\_\_\_\_

Group # \_\_\_\_\_

Treatment description: \_\_\_\_\_

Date of treatment: \_\_\_\_\_

Reason for denial: \_\_\_\_\_

Date denial received: \_\_\_\_\_

Date appeal filed: \_\_\_\_\_

**Conversation:**

Date: \_\_\_\_\_

Name of contact: \_\_\_\_\_

NOTES:

Follow-up required:

Follow-up date: \_\_\_\_\_

**Conversation:**

Date: \_\_\_\_\_

Name of contact: \_\_\_\_\_

NOTES:

Follow-up required:

Follow-up date: \_\_\_\_\_