Parkland
Community Health Plan, Inc.

Claims Reconsideration & Appeals Form

Complete this form and return to Parkland Community Health Plan for processing your request.

- ☐ Request for reconsideration:
  Please choose one of the following reasons:
  - ☐ Corrected Claim
  - ☐ Itemized bill/medical records (in response to a claim denial)
  - ☐ Other insurance/third-party liability information
  - ☐ New Texas Provider Identifier (TPI) issues or re-attestation
  - ☐ Other:

    _____

- ☐ Claim Appeal
  Please choose one of the following reasons:
  - ☐ Authorization issue. Authorization Number is _____
  - ☐ Eligibility issue
  - ☐ Incorrect payment per the contract
  - ☐ Timely filing
  - ☐ Other:

    _____

Provider Name*	Provider Tax ID*
Provider NPI*	Date of last Explanation of Payment*
Parkland Claim Number*	Dates of Service (provide a range if multiple claims)*
Member Name*	Member ID*

(*Indicates a required field)

Attach all documentation and return to:

Parkland Community Health Plan
PO BOX 569150
Dallas, TX 75356-9150

Person requesting _____
Phone Number _____
Date _____