



Provider Claims Appeal Form

Children First Medical Group, Inc.
 Claims Department
 Attention: Claims Manager
 6425 Christie Ave., Ste. 110
 Emeryville, CA 94608-2245

Instructions: Appeals must be submitted within three hundred and sixty-five (365) days from the original date of a claims denial and/or billing dispute. To expedite processing of your appeal, please print the information requested below and attach a copy of the original claim, if available, as well as any supporting documentation. Submit appeals to the attention of the Claims Department, Claims Manager.

Provider Name:	Date:
Address:	
Telephone Number:	Fax Number:
Contact Name:	
Patient Name:	
Member ID Number:	
CFMG Claim Number:	
Date(s) of Service/Billed Amount:	
Reason you believe claim was improperly denied, in whole or in part:	
Internal Use Only:	
Date Received:	Date Completed:
Completed By:	Signature:
Comments	