AMM
ADVANCED MEDICAL MANAGEMENT, INC.

CMSP
COUNTY MEDICAL SERVICES PROGRAM

Claim Appeal/Dispute Form

Provider Information

Contact Name	Date
Hospital/Facility/Physician Name	Phone Number
NPI Number	Provider Tax ID Number

Member Information

Patient Name	Date of Service
Member ID Number (CIN)	Claim or DCN Number

INSTRUCTIONS: Only submit one claim per Claim Appeal/Dispute form. You must submit your request for consideration in writing or by fax within 60 calendar days from the date of the provider's receipt of our Explanation of Benefits (EOB). Include this completed form, a copy of the original and/or corrected CMS 1500 or UB04 claim form, and supporting documentation not previously considered to:

CMSP- Advanced Medical Management
Attn: Claim Appeals
5000 Airport Plaza Drive Suite 150
Long Beach, CA 90815
Fax (562) 766-2007

Please explain the reason why you are appealing the above noted claim.