Provider request for Claim Appeal/Reconsideration Review

Do not attach claim forms unless changes have been made to the original claim that was submitted. Please attach supporting documentation to facilitate your review. This form must be placed at the top of the correspondence you are submitting.

Reason for Appeal Review **(if further space is required, use the back of this form or attach additional material).** Please include detailed information as to the nature of your claim appeal/reconsideration review. If a corrected claim has been attached please specify corrections that were made:

Please mail to the following address:

Davis Vision, Inc.
Attn: Quality Assurance – Provider Appeals
711 Troy Schenectady Rd.
Latham, NY 12110

Claim Data:

Member ID Number:	
Member Name:	
Patient's Name:	
Date of Service:	
Billed Amount:	
Davis Vision Authorization Number:	

Provider Data: **Today's Date:**

Provider Number:	
Provider Name:	
Address:	
Contact Person:	
Phone Number:	