CLAIMS ELECTRONIC APPEALS PROCESS FORM

This form is to be used for all timely filing appeal requests.

Appeal requests should be sent to: **cbhclaims.appeal@phila.gov**

Parent Number:	
Provider Name:	
Location:	
Your Name (Requestor):	
Impacted Level(s) of Care (LOC) *(Please use the LOC format 300-10, 200-7, 600-105)**:***	
Start Date:	
End Date:	
Program/Child Numbers:	
Outstanding Amount:	
Reason for Delay:	