Provider Appeal Form

Please submit this form with documentation/medical records supporting your appeal. Once PHP receives this form, you will get an official letter of confirmation of the initiated appeal process.

Please choose your type of appeal:

CLEAR FORM

☐ **Claim Related**

☐ **Denied Authorization**

Member Name:	**Provider Name:**
Member Number:	**Provider Number:**
Date of Service:	**Contact Name:**
Claim Number:	**Contact Phone Number:** **Contact Fax Number:**
Claimed Amount:	**Contact Address:**

Please provide a detailed description of your appeal:

Please Send Appeal To:

Physicians Health Plan
Attention: Customer Service Provider Appeals
PO Box 30377
Lansing, MI 48909
Or Fax to: (517) 364-8411
Monday-Friday, 8am-5pm, except holidays