HCAP Claims Appeal Form

Date:

Provider Information

Provider Name:

Tax ID Number (e.g., XX-XXXXXXX):

HCAP Invoice(s) (e.g., XXXXX*X*X):

Appeal Reason:

Patient Information

Patient Name:

Patient Date of Birth:

Date(s) of Service:

Please attach the following:

- *Copy of original medical claim(s) (CMS-1500 or UB-04)*
- *Appeal supporting documentation*

Submit this HCAP Claims Appeal Form along with medical claim(s) and supporting documentation to the email address hcapbillpay@mchd-tx.org.

*A response to your appeal will be issued within **30 days** from appeal receipt.*

For further information regarding HCAP billing practices, please review our Bill Pay FAQs.