**State of Vermont**
**Department of Vermont Health Access (DVHA)**
**Provider's Timely Filing Appeal Claims List for 10 or more claims**

| Recipient First & Last Name | Original ICN or Date Claim was Submitted To HPES | MID Number | Date of Service | | Total Billed |
|---|---|---|---|---|---|
| | | | Beginning | Ending | |
| | | | | | |
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