COMMUNITY Health Options™

Provider Appeal Form

BEFORE PROCEEDING, NOTE THE FOLLOWING:

- This form is only used for requesting a formal appeal of any adverse determination (i.e. claim denial, medical necessity denial, benefit denial, or eligibility decision).
- We recommend utilizing an applicable reconsideration process before using this form to file a formal appeal. Details on the reconsideration process are available on our website, or from our Service Associates by telephone, (855) 624-6463.
- For Express Scripts Pharmacy authorization appeals, please contact Express Scripts directly, (800) 282-2881.
- Do not submit corrected or new claims with this form.
- Use a separate appeal form for each adverse determination appeal.

INSTRUCTIONS:

Complete all applicable areas of this form, attach supporting documentation (including a copy of any adverse determination correspondence, if applicable) and submit all documentation via mail, email, or fax using the address or fax number at the end of this form. For claim reconsideration denials, appeals must be submitted within 90 calendar days from the date of the reconsideration denial letter or 180 calendar days of the date of the Explanation of Payment (EOP). For medical necessity or benefit denials, appeals must be submitted within 180 calendar days of the date on the denial correspondence. Please allow up to 30 calendar days for Community Health Options to process your appeal.

REQUESTS FOR REVIEW SHOULD INCLUDE:

1. This completed form including the reason(s) why you believe the denial or adverse determination is incorrect and should be modified.
2. Supporting documentation that includes the original denial correspondence (i.e. denial letter, reconsideration denial, EOP with claim denial), specific reasons for untimely notification or no prior authorization obtained (for benefit denials), additional medical records (for medical necessity denials), or detailed, related information for claim or eligibility denials, as applicable.

MEMBER INFORMATION			
Member ID:		Claim #	
Date of Service:	Billed Amount:	Allowed Amount:	
Authorization #	CPT Code:		
Member Name – Last		First:	MI:
Member Date of Birth (DOB):		State:	ZIP:

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION			
Tax Identification Number (TIN):	Phone Number:	Email Address:	
Physician Name as listed on Explanation of Payment (EOP)			
Last:		First:	Provider NPI:
Practice Service Address:		State:	ZIP:
Facility/Group Name:		Contact Person:	
Amount Owed (Optional)			

Please select the issue that best describes your reconsideration. The initial decision was related to:

- ☐ Mutually exclusive, incidental, bundling, or duplicative procedure code denial
- ☐ Contract and/or fee schedule or reimbursement terms
- ☐ Modifier reimbursement: List modifiers:_____
- ☐ Timely claim filing (please include proof of original submission, if applicable)
- ☐ Medical necessity
- ☐ Failure to obtain prior approval authorization
- ☐ Request for in-network benefits
- ☐ Benefit plan exclusion or limitation
- ☐ Reinstatement of coverage termed due to non-payment of premiums
- ☐ Other (please indicate):_____

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State the reason for the appeal and expected outcome below and attach supporting documentation.

Has anyone at Health Options tried to resolve the situation? If yes, please explain.

Name of Requestor:	Title of Requestor:
Phone #:	Email Address:
Address (for notices regarding this request):	
Signature:	Today's Date:

Mail, or scan and e-mail this completed form along with all supporting documentation to:

Fax: 877) 314-5693

E-mail: appeals@HealthOptions.org

Mail: MAIL STOP 800
ATTN: APPEALS
COMMUNITY HEALTH OPTIONS
P.O. BOX 1121
LEWISTON, ME 04243-1121