COMMUNITY Health Options®

Provider Appeal Form

Before Proceeding, Please Note the Following

- This form is only used for requesting a formal appeal of any adverse determination (e.g., medical necessity denial, benefit denial, or eligibility decision).
- This form cannot be used to contest claim payments/denials except those associated with benefit denials, benefit limit denials, or eligibility denials – all other claim denials must be submitted as a Claim Reconsideration
- For pharmacy appeals, please call the phone number on the back of your insurance card for more information.

Instructions

Complete all applicable areas of this form, attach supporting documentation (including a copy of any adverse determination correspondence, if applicable), and submit via mail, email, or fax. Appeal submission deadlines are listed at the end of this form.

Member Information

First Name	M.I.	Last Name	Date of Birth	Member ID #

Address	City	State	Zip Code

Claim #	Date of Service	Billed Amount $	Allowed Amount $	Authorization #	CPT Code

Provider Information

Facility/Group Name	Tax Identification Number (TIN)	Phone Number	Email

Street Address	City	State	Zip Code

Contact Person	Physician Name as Listed on EOP	Provider NPI	Amount Owed $

Select the Applicable Issue

☐ 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
☐ Other (please indicate): _____

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

Has anyone at Community Health Options tried to resolve the situation? If yes, please explain and provide the reference number(s) associated with the contact or call.

Before Proceeding, Please Note the Following

By completing the attestations below, the Provider acknowledges that this form is pursuant to Maine Bureau of Insurance Rule Chapter 850, Section 8.G.1.a.1. We will be unable to process your appeal without the attestations below filled out and dated.

Attestations

☐ We, the provider, have notified the covered person in writing at least 14 days before filing this appeal of the intent to file this appeal.

☐ We attest that we notified the covered person in writing within 7 days after filing this appeal.

Notification sent on: _____

Requester Information	
Name of Requester	Title of Requester
Phone	Email
Return Address (for notice regarding this request)	
Signature	Date

Email, mail, or fax this completed form along with all supporting documentation to:

Email: appeals@healthoptions.org - Please utilize a secure email method only, to protect your private information. Check with your email provider if you are unsure if your email is considered secure.

Mail: ATTN: Appeals
Community Health Options
Mail Stop 800
P.O. Box 1121
Lewiston, ME 04243-1121

Fax: (877) 314-5693

Appeal Deadlines		
	Level I Appeals	**Level II Appeals**
Community Health Options Fully Insured Members	180 calendar days from the EOP or adverse determination correspondence date	180 calendar days from the Level I Appeal decision date
Members of self-insured plans	180 calendar days from the EOP or adverse determination correspondence date	60 calendar days from the Level 1 Appeal decision date