Service Appeal Request Form

Fax to: 313-591-1155

Contact Information

Contact Name | **Phone** | **Fax** | **Date**

General Information

Severity: ☒ Standard ☐ Urgent Clinical reason for urgency:

Appeal Type:
Check all that apply

☐ Inpatient ☐ Initial ☐ SNF/IPR/LTAC
☐ Outpatient ☐ Concurrent ☐ Retrospective

Patient Information

Name | DOB | Member ID | Sex

Address | City | State | Zip

Subscriber Name (If Different)

Provider Information

Name | NPI (required)

Tax ID

Phone | Fax

Address | City | State | Zip

Appeal Information

Case # of denied OD | CPT code

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Additional Clinical Explanation

***Please attach clinical documentation to faxes such as signs, symptoms, history, diagnostic test results, consultant recommendations (if applicable), and plan of treatment. Requests *cannot* be processed without this documentation. ** Comments:**

Additional information and instructions:
Contact information for the person requesting the authorization. This is the person that will be called with questions. If overturned the form will be faxed back to this fax number. If upheld, the denial letter will be faxed to this number and mailed to the "requesting physician".

Requesting Provider Attestation Statement

I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

*Printed Name:*_____ *Signature:*_____ *Date* ___ / ____ /_____

Appeal Contact: 844-279-0508