

**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:**  Inpatient  Initial  SNF/IPR/LTAC  
\*Check all that apply\*  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  
   
Case # of denied OD CPT code

**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**