

# Provider appeal form: Level I

## When to use this form:

- **Participating providers:** Complete and submit this form for retrospective reviews prior to claim submission and previously denied provider liability (denied for medical necessity).
- **Out-of-network providers:** Complete and submit this form to request a formal appeal or a retrospective review.

Submit a separate appeal form for each appeal.

## Priority Health Medicare reviews or appeals:

If your patient has Priority Health Medicare, please review the **Reviews and appeals** section of our Provider Manual.

## Do not use this form:

- Instead of using this form, participating providers should log in to the Provider Portal to submit appeals, medical records and to status claims.

## Requirements:

- Appeals submitted without this form will be returned unprocessed
- Complete the appeal form so that Priority Health clearly understands the request, otherwise it will be returned for insufficient explanation
- All pertinent supporting documentation must be attached

**Deadline:** Within 180 days of the first remittance advice

## Submitter contact information

|                        |        |              |
|------------------------|--------|--------------|
| Provider/facility name | Tax ID | Contact name |
|                        |        |              |
| Phone                  | Fax    | Email        |
|                        |        |              |
| Address                |        |              |
|                        |        |              |

## Member information

|                  |                   |                  |
|------------------|-------------------|------------------|
| Member last name | Member first name | Member ID number |
|                  |                   |                  |

## Claim information (Out-of-network providers only)

|                |                                                           |                 |
|----------------|-----------------------------------------------------------|-----------------|
| Claim number   | Date(s) of service(s)                                     | Total charge(s) |
|                |                                                           |                 |
| Inquiry number | Disputed codes<br>(must include supporting documentation) |                 |
|                |                                                           |                 |

**Explanation of appeal, including denial reason** (letter is required for medical necessity and related readmission appeals. If not documented, the appeal will not be reviewed.)

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