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 (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.)
