COMMUNITY Health Options®

☐ Level I ☐ Level II

Member Medical / Claim Appeal Form

BEFORE PROCEEDING, NOTE THE FOLLOWING:

- This form is only used for requesting a formal appeal of any adverse determination.
- Pharmacy appeals please contact the phone number on the back of your insurance card for more information.
- This form is for use by Members enrolled in a fully-insured plan from Community Health Options and Members enrolled in a self - insured employer plan. If a Member of a self - insured employer plan, please also fill out an Appointment of Authorized Representative Form

INSTRUCTIONS:

Please fill in as many of the fields on this form that you are able, attach supporting documentation and submit everything to us via mail, secure email, or fax by using the address or fax number at the end of this form. Please allow up to 30 calendar days from the date your appeal is received for Community Health Options to process your appeal.

REQUESTS FOR APPEAL SHOULD INCLUDE:

1. This signed form including the reason(s) why you believe the adverse determination is incorrect and should be changed.
2. Supporting documentation that you feel will assist us in reviewing your appeal.

Member Information			
Member ID:		Claim #:	
Date of Service:	Billed Amount:	Authorization #:	
Member Name - Last:		First:	MI:
Member Date of Birth (DOB):		State:	ZIP:

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION		
Physician, Provider or Practice Name:		
Practice Address:	State:	I ZIP:
Contact Person:		
Amount Owed (Optional):		

Please select the issue that best describes your appeal. The initial decision was related to:

☐ Claim processing
☐ Out-of-pocket / deductible / coinsurance amounts
☐ Medical necessity
☐ Other (please indicate)

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

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

Name of Requestor:	Relationship to Member:
Phone#:	Email Address:
Return Address (for notices regarding this request):	
Signature:	Today's Date:

Mail, fax, or scan and e-mail this completed form along with all supporting documentation to:

E-mail: 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.

Fax: (877) 314-5693

Mail: MAIL STOP 800

ATTN:APPEALS
COMMUNITY HEALTH
OPTIONS P.O. BOX 1121
LEWISTON, ME 04243-1121

Appeal deadlines:

	Level One Appeals	**Level Two Appeals**
Community Health Options Fully Insured Members	180 calendar days from the EOP or adverse determination correspondence date	180 calendar days from the Level One 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 One Appeal decision date