COMMUNITY Health Options®

Provider Medical / Claim Appeal Form

Before Proceeding, Please Note the Following

- If this appeal is for a Member of a self-insured employer plan, you must include an executed Authorization for Disclosure of Protected Health Information form with the appeal.
- This form is only used for requesting a formal appeal of any adverse determination (e.g., claim denial, medical necessity denial, benefit denial, or eligibility decision).
- We recommend using the applicable reconsideration process before using this form to file a formal appeal. Details on the reconsideration process are available on our website or by calling (855) 624-6463.
- For pharmacy appeals, please call the phone number on the back of your insurance card for more information.
- Do not submit corrected or new claims with this form; use a separate appeal form for each adverse appeal.

Instructions

Complete all applicable areas of this form, attach supporting documentation (including a copy of any adverse determination correspondence, if applicable), and submit via mail, email, or fax. Claim reconsideration denials are not formal denials as the reconsideration process is optional. Appeal submission deadlines are listed at the end of this form.

Member Information

First Name	M.I.	Last Name	Date of Birth	Member ID #

Address	City	State	Zip Code

Claim #	Date of Service	Billed Amount $	Allowed Amount $	Authorization #	CPT Code

Provider Information

Facility/Group Name	Tax Identification Number (TIN)	Phone Number	Email

Street Address	City	State	Zip Code

Contact Person	Physician Name as Listed on EOP	Provider NPI	Amount Owed $

Select the Applicable Issue

- ☐ Mutually exclusive, incidental, bundling, or duplicative procedure denial
- ☐ Contract and/or fee schedule or reimbursement terms
- ☐ Modifier reimbursement: List modifiers: _____
- ☐ Timely claim filing (please include proof of original submission, if applicable)
- ☐ Medical necessity
- ☐ Failure to obtain prior approval authorization
- ☐ Request for in-network benefits
- ☐ Benefit plan exclusion or limitation
- ☐ Reinstatement of coverage termed due to non-payment
- ☐ Other (please indicate): _____

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

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

Requester Information	
Name of Requester	Title of Requester
Phone	Email
Return Address (for notice regarding this request)	
Signature	Date

Email, mail, or fax this completed form along with all supporting documentation to:

Email: 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: ATTN: Appeals
Community Health Options
Mail Stop 800
P.O. Box 1121
Lewiston, ME 04243-1121

Appeal Deadlines		
	Level I Appeals	**Level II Appeals**
Community Health Options Fully Insured Members	180 calendar days from the EOP or adverse determination correspondence date	180 calendar days from the Level I 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 1 Appeal decision date