Provider Appeal Form

Use this form if you have received a reconsideration denial or wish to submit an appeal on behalf of a Member:

Please submit the completed form to:

For Level I Appeals Regarding Prior Approval Denials:
Community Health Options
Maine Stop 800
P.O. Box 1121
Lewiston, ME 04243

For All Other Appeals:
Community Health Options
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243

Member ID:	Community Health Options Claim #	
Date of Service:	Billed Amount:	Allowed Amount:
Member Name – Last:	First:	MI:
Member Date of Birth (DOB):	State:	Zip:
Patient Name: Last	First:	MI:
PHYSICIAN / HEALTH CARE PROFESSIONAL INFORMATION		
Tax Identification Number (TIN):	Phone Number:	Email Address:
Physician Name (as listed on Explanation of Payment (EOP)) / Explanation of Benefits EOB:		
Last:	First:	Provider NPI:
Practice Service Address:	State:	Zip:
Facility / Group Name:	Contact Person:	
Authorization # (if applicable):		

Describe the Appeal in as much detail as possible. Be sure to include all person(s) and place(s) involved and any information you believe to be relevant for the reviewer. Include all supporting documentation with this request form and the desired outcome.

CONTINUED ON NEXT PAGE

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Name of Requestor:	Title of Requestor:
Phone #:	Email Address:
Signature:	Today's Date: