

Appeal Request Coversheet

Appeal requests can emailed to **appealsgrievances@chpw.org** or faxed to **(206) 613-8984**

Please check urgency of appeal:

- Routine Medically Urgent (Fax number: **206-613-8983**)

Medically Urgent means delaying a decision for more than 72 hours could cause an emergency or put the member's life in danger, put at risk their ability to get, keep, or get back maximum functioning.

PROVIDER INFORMATION									
First Name:	Last Name:	Office/Provider Rendering Service:							
Phone #:	Fax #:								
PATIENT INFORMATION									
First Name:	Last Name:	MI	Date of Birth:						
CHPW Member ID#:	Plan/Program:								
APPEALS REQUEST:									
<input type="checkbox"/> 1st Level <input type="checkbox"/> 2nd Level									
Please check what is being denied: <input type="checkbox"/> Prior Authorization/Referral/Inpatient Notification <input type="checkbox"/> Medication <input type="checkbox"/> Claim Payment*									
*For claim payment denial, please check the reason for denial:									
<input type="checkbox"/> No Prior Authorization/Referral <input type="checkbox"/> Late Inpatient Notification <input type="checkbox"/> Post Payment Review <input type="checkbox"/> Billing/Coding									
<input type="checkbox"/> Pre-existing condition <input type="checkbox"/> Not medically necessary <input type="checkbox"/> Duplicate									
Certification Number:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 2px;">Claim Number(s) and Date(s) of Service:</td> <td style="padding: 2px;">1.# _____ / Date: _____</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;"></td> <td style="padding: 2px;">2.# _____ / Date: _____</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;"></td> <td style="padding: 2px;">3.# _____ / Date: _____</td> </tr> </table>			Claim Number(s) and Date(s) of Service:	1.# _____ / Date: _____		2.# _____ / Date: _____		3.# _____ / Date: _____
Claim Number(s) and Date(s) of Service:	1.# _____ / Date: _____								
	2.# _____ / Date: _____								
	3.# _____ / Date: _____								
Please add any additional claim numbers in the Appeal Summary.									
Date(s) of Denial (s):									
APPEAL SUMMARY: Please indicate below your reasoning for why the adverse decision chosen above should be overturned.									
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Please attach denial information that you have received from CHPW to this form (letters, EOB's, etc.) in addition to any letters of appeal and medical records being submitted for review.