



Provider for Member Appeal Request

Pre-Service on behalf of a CHPW member

Use this form to **appeal a pre-service coverage decision** on behalf of a Community Health Plan of Washington (CHPW) **Apple Health (Medicaid)** member. Please also include a Member Consent form signed by the member.

Appeal requests must be received by CHPW within 60 days of the date on the denial letter.

Email: AppealsGrievances@chpw.org (preferred) Fax: 206-613-8984

Urgency of Appeal			
If selecting Medically Urgent*, please include the reason in the Appeal Summary. <input type="checkbox"/> Routine (Standard) <input type="checkbox"/> Medically Urgent (Request for Expedited Review) <i>*Delaying a decision more than 72 hours could cause an emergency, put the member’s physical or mental health at serious risk, or if it involves a mental health drug authorization. Fax urgent requests to 206-613-8983.</i>			
Provider Information			
Provider First and Last Name		Clinic/Office Name	
Email	Fax	Phone Number	
What is the best way to contact you? <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Phone			
Member Information			
Member First and Last Name			Date of Birth
CHPW Member ID Number		Member’s Health Plan or Program	
Appeal Details <i>(Check what was denied)</i>			
<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Medication <input type="checkbox"/> Referral Name of Service, Medication, or Referral:			
Reference or Prior Auth. Certification Number		Date of Denial	

Appeal Index and Summary

To help us review efficiently, for each document you submit, please list the specific page numbers that support your argument. Also, share the reason for your appeal and why you disagree with our reason for denial.

If more space is needed, attach an additional document titled "Appeal Index and Summary".

Documents to Include *(Include supporting page numbers in the Appeal Index and Summary above if possible.*

Attach all **relevant** denial information (denial letters, EOB's, etc.), appeal decision letters, and medical records that support medical necessity. Examples of appropriate documents include:

- **Recent** (≤ 6 months) **physician notes** documenting the condition and need for services.
- **Lab and/or radiology** results.
- **Specialty consultation** notes.