Medicare Appeal Request Form

To prevent unnecessary delay in processing this appeal, please follow the steps below.

1. Fax or mail the appeal with all appropriate documentation
   Fax – 920-720-1832
   OR
   Address – Network Health
   Attn: Appeals and Grievance
   P.O. Box 120
   Menasha, WI 54952
2. Include any clinical notes or office notes that would support the appeal. **If this information is not provided, it could significantly delay processing and affect the ultimate decision** that needs to be made based on the information we have received.

Please check the grievance category below that most appropriately matches your patient's situation.

☐ **Standard Pre-Service Request** (the service has not yet been rendered and your patient's condition is not considered life threatening. A determination will be made no later than 30 calendar days for medical, and 7 calendar days for pharmacy, after receipt of the appeal request).

☐ **Expedited Pre-Service Request** (the service has not yet been rendered **and** the physician confirms that this is a life-threatening situation where the patient's life, health or ability to regain maximum function could be in serious jeopardy if Network Health does not decide the appeal quickly. If this is a life-threatening situation, Network Health will decide the appeal within 72 hours of receipt).

Describe rationale for expedited request:

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☐ **Standard Post-Service Request** (the service has already been rendered. A determination will be made no later than 60 calendar days after receipt of the appeal request).

Please describe what you are appealing. Be specific:

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Name and title of person filling out form: ____

Contact phone number: ______________________ **Contact fax number**: ________________________

(More information on back)

Medicare Appeal Request Form

<table>
<tr><td>Member Name:</td><td colspan="2">Member ID Number:</td><td>Date of Birth:</td></tr>
<tr><td colspan="2">Ordering MD Phone Number:</td><td colspan="2">Ordering MD Fax Number:</td></tr>
<tr><td colspan="4">Rendering Provider or Facility:</td></tr>
<tr><td colspan="2">Rendering Provider or Facility Phone Number:</td><td colspan="2">Rendering Provider or Facility Fax Number:</td></tr>
<tr><td colspan="4">ICD-10 Diagnosis Code(s):</td></tr>
<tr><td colspan="4">Requested Type of Service and CPT/HCPCs code:</td></tr>
<tr><td colspan="4">Signed Appointment of Representative (AOR) if applicable: ☐ Yes ☐ No
(please send signed form with this request)</td></tr>
<tr><td colspan="2">Appeal notification made to Member: ☐ Yes ☐ No</td><td colspan="2">Appeal notification made to MD: ☐ Yes ☐ No</td></tr>
</table>

Comments: ______________________________

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