Medicare Appeal Request Form

1. To prevent unnecessary delay in processing this grievance, please follow the steps below.
2. Fax or mail the appeal with all appropriate documentation
   a. Fax: (920) 720-1832
   b. Address: Network Health, Attn: Appeals and Grievance
      P.O. Box 120
      Menasha, WI 54952
3. 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: _____

☐ **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).

*If warranted Network Health may execute an extension to any of the above time frames as allowed by CMS.

Please describe what you are appealing. Be specific: _____

Name and Title of Person Filling Out Form: _____

MD Signature (authorization of appeal on behalf of member): _____
Contact Phone Number: Contact Fax Number:

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

Comments

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