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 #	HOW SHOULD WE REACH YOU?

PATIENT INFORMATION

First Name:	Last Name:	MI	Date of Birth:
CHPW Member ID#:	Plan/Program:		

APPEALS REQUEST:

☐ 1st Level ☐ 2nd Level

Please check what is being denied: ☐ Prior Authorization/Referral/Inpatient Notification ☐ Medication ☐ Claim Payment*

***For claim payment denial, please check the reason for denial:**

☐ No Prior Authorization/Referral ☐ Late Inpatient Notification ☐ Post Payment Review ☐ Billing/Coding

☐ Pre-existing condition ☐ Not medically necessary ☐ Duplicate

Certification Number:

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.

_____

_____

_____

_____

_____

COMMUNITY HEALTH PLAN of Washington™

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.

Updated: 02/2023