Provider Appeal Form – 1st Level of Appeal

This form is for **providers** to request an appeal after they receive an adverse coverage decision (PA, Claim). Supporting documentation must be included; this may include, but is not limited to: medication history, diagnostic workup, lab results, chart notes, etc.

Who May Request a Level 1 Appeal

Part C - Standard Pre-Service/Expedited Pre-Service
The enrollee's treating physician acting on behalf of the enrollee or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider).

Standard Payment Reconsideration
Non-contract provider (see §50.1.1 for non-contract provider payment appeals).

Part D - Standard or Expedited Redetermination
An enrollee's prescribing physician, another prescriber acting on behalf of the enrollee, or the staff of a physician's office acting on a physician's behalf (e.g., request is on the office's letterhead).

Please fax or mail completed form and supporting documentation to:
Fax: 1-866-339-8751

Appeals and Grievances
2965 Ryan Drive SE
Salem OR 97301

Important Note for Expedited Decisions

Medical Item/Service - If you believe that waiting 30 days for a standard decision could seriously harm your patient's life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. You cannot request an expedited appeal if you are asking us to pay for a service/item the member has already received.

Medicare Prescription Drug - If you believe that waiting 7 days for a standard prescription drug decision could seriously harm your patient's life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS.**

Expedited appeal requests can also be made by phone at: **1-877-672-8620** (TTY 711), daily from 8 a.m. to 5 p.m. PST.

Provider/Physician Information*		
Provider Name:	Date:	
Address:		
City:	State:	Zip:
Telephone #:	Fax #:	

Service/Medication Requested:	Quantity:
Diagnosis:	
Reason for Appeal (check one): Claim denied ☐ Authorization does not cover services rendered ☐ Prior Authorization denied ☐	
Date of Service (if applicable):	Date of Decision Notice:
Patient Information*	
Patient Name:	DOB:
Patient Member ID #:	
PA Case #, Reference #, or Rx#:	

Please indicate why the service/medication is medically necessary for the patient:*

Provider's Signature: **Date of Signature:** **Time of Signature:**