Internal Appeal Filing Form

Please clearly PRINT all information

Member Name: ___________________________________ Member ID# :_______________________________________

Name of Person Completing Form *(if other than member)*: ____

Check all that apply to person completing form: ❑ Member ❑ Authorized Representative*

Contact Information of Person Completing Form:

Address: ____

Daytime Phone: ____

For Authorized Representative*

*Member Signature is Required: **____**

**A valid HIPAA authorization form is required for the Plan to disclose protected health information to an authorized representative. If Nova does not have a valid HIPAA authorization on file for the authorized representative, a HIPAA authorization form will be mailed to the address above. An appeal submitted by an authorized representative cannot be processed without a valid HIPAA authorization.*

Briefly describe why you disagree with this decision:

You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim. Standard appeal decisions are made within 15 days.

Certification: *I hereby authorize Nova to release to the Peer Reviewer documents or information regarding the requested service(s). I acknowledge that Nova associates will access and review information to process this appeal.*

Member Signature: ____ Date: ________________________

Return this form and denial notice to: Nova Healthcare Administrators, Inc., P.O. Box 1543, Buffalo, New York 14231

Keep copies of this form, your denial notice, and all documents and correspondence related to the service request.

Urgent appeals are available only for services that have not yet been provided.

*For URGENT appeals the **treating physician must complete** the information below. Only in urgent situations may the provider act as the Authorized Representative without requiring the member's signature.*

❑ My patient's health would be in serious jeopardy if required to wait for a standard appeal decision.
❑ My patient would experience pain that cannot be adequately controlled if required to wait for a standard appeal decision.

Certification: *I hereby certify that the above, in my professional opinion, presents an urgent situation requiring that my patient's appeal (member) be expedited.*

Name of Treating Physician (please print): ____

____ ________________________ ________________________

Treating Physician Signature *Date* *Phone*