APPEAL FILING FORM

Name of Participant: ____ **ID#:** ____________________________

Name of Person Filing Appeal: ____

Address: ____

Daytime Phone #: ____________________________ **Email:** ____

Individual completing form is: ❑ Subscriber ❑ Dependent ❑ Authorized Representative*

*For "Authorized Representative," the participant must sign here and comply with the notice below to authorize a representative to act on his/her behalf: ____

PLEASE NOTE: *Signing above does not automatically authorize the representative to proceed on behalf of the participant. A HIPAA authorization is required before protected health information can be shared with a representative. An appeal cannot be processed without a completed HIPAA authorization. A special authorization may also be required for behavioral health and family planning matters involving a participant over the age of 13.*

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.

I hereby authorize Nova Healthcare Administrators, Inc. ("Nova") to release to the members of the Appeals Committee or Clinical Review Committee any records or information regarding the services in question. I acknowledge that Nova employees who need to know information pertaining to the services in question to process this appeal will have access to and may review such information.

Signature: ____ **Date:** ______________________

Send this form **<u>and a copy of your denial notice</u>** **to:** Nova Healthcare Administrators, P.O. Box 1543, Buffalo, NY 14231

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

Urgent appeals are available <u>only</u> for services that have not been provided.

Are you requesting an urgent appeal? ❑ Yes* ❑ No

*If yes, you must have your <u>treating physician</u> check the appropriate box(es) below and sign the certification.

❑ 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 this participant's (my patient) appeal be expedited.

____ ___________________ ______________________

Treating Physician Signature **Date** **Phone**

Print Name: ____