Appeal Filing Form

Please clearly PRINT all information

Member Name: ____________________________________ **Member ID#**: ____

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

Phone number, address and email of person completing form: Daytime Phone #: __________________________________

Address: ____ Email: _______________________________________

Individual Completing this form: ❑ Member ❑ Authorized Representative*

For Authorized Representative*

*Member Signature is Required: ____

**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 submitted by a representative cannot be processed without a valid 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.

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I hereby authorize Nova Healthcare Administrators, Inc. to release to member of the Appeals committee any records or information regarding the service(s) in question. I acknowledge that Nova associates will access and review information pertaining to the service(s) in question to process this appeal.

Member Signature: ____ **Date**: ________________________

Return this form <u>and a copy of your denial notice and any other supporting documentation</u> to: Nova Healthcare Administrators, Inc., P.O. Box 1543, Buffalo, New York 14231 or Fax to (716) 250-7170

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

If you are filing an appeal for a claim denial for services that have already been rendered, **DO NOT** Complete the following section.

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*