



Appeal Filing Form

What if I don't agree with this decision?

Members or providers may appeal any denial in whole or in part.

What if I need help understanding this denial?

Contact us at 801-366-7555 or 800-765-7347 or visit www.pehp.org for benefit information.

How do I file an appeal?

Fill out the bottom of this page and send a copy to PEHP Appeals and Policy Management Department, P.O. Box 3836, Salt Lake City, UT 84110-3836. You must include a completed form. Go to www.pehp.org for more instructions and forms.

Who may file an appeal?

You or someone you name to act for you. Go to www.pehp.org to get a form to authorize another person to represent you, including your provider.

Can I provide additional information about my claim?

Yes, please provide all pertinent information. Keep a copy of everything you submit.

What happens next?

We'll let you know in writing what we decide regarding your appeal. If your appeal is denied, you may be

able to request an external review of your claim by an independent third party who will review the denial and issue a decision. There is a \$25 charge for the external review. If the external reviewer agrees with you, the \$25 will be refunded. This option is only available to the member or member's authorized representative and only if medical judgement was required for the decision.

Can I request copies of information relevant to my claim?

All information reviewed by PEHP in denying your claim is available to you free of charge. This includes billing and diagnoses codes. Send a request in writing to the address at the bottom.

What if my situation is urgent?

If your situation meets the definition of urgent under federal law, your review will generally be conducted within 72 hours. An urgent situation is generally defined as one in which your health may be in immediate serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you await a decision. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an appeal and also checking the boxes requesting an urgent appeal. Urgent appeals aren't available for disputes involving services you've already received.

Name of person filing appeal: _____

Member ID#: _____

Patient name: _____

Email Address: _____

Daytime phone number: _____

Claim number/PA number or date of service: _____

Relationship to patient: Self Parent (if patient is a minor child) Provider Authorized Representative (*attach authorization form*)

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 understand my information may be sent to a Board Certified Physician who reviews medical necessity of my claim. If additional clinical information is needed to review my appeal it will be requested by PEHP directly from a provider. Any charges billed by a provider for obtaining such information are not the responsibility of PEHP.

Are you requesting an urgent appeal? Yes No (Urgent appeals are allowed only in Accordance with federal law)

Signature: _____ Date: _____

Send this form to:

PEHP Appeals and Policy Management Department, PO Box 3836, Salt Lake City, UT 84110-3836. Or fax to 801-320-0541. **Keep a copy of this form, your denial notice, and all documents/correspondence related to this claim.**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711)