



Appeal Filing Form

What if I don't agree with this decision?

Within 180 days of the initial determination, 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)



Appointment of Authorized Representative*

You can represent yourself, or you may ask another person to act as your authorized representative, including your provider. You may revoke this authorization at any time by giving written notice to PEHP (Note: You do not have to fill this out if you are representing a member dependent on your plan, i.e. spouse, child).

PEHP Member ID number: _____

I hereby authorize _____ to represent me in appealing
PEHP's decision of: _____.

Signature of patient or parent of minor child

Date

Print name: _____

Work/home/cell number: _____

Email address: _____

Signature of Authorized Representative,

Print name: _____

Address of Authorized Representative: _____

Email address: _____

Daytime Phone: _____

*Attach this form to the Appeal Filing Form.

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Consent to Release Medical Records Request for External Review

To request an external review by a Board Certified Physician in the specialty concerning your appeal, you must sign and date this external review request form and consent to the release of medical records. A payment of \$25 must accompany this form (check or money order). If the Reviewer agrees with you, the claim will be paid according to the Reviewer's decision and your \$25 will be returned. If the Reviewer denies your claim, the \$25 will not be returned.

I, (print name) _____, hereby request an external appeal. I authorize PEHP to release all medical or treatment records regarding this appeal to the Independent Reviewer. I understand that the Independent Reviewer will use this information to make a determination on my appeal. This release will be valid for one year and the information will not be released to anyone else or used for any other purposes.

_____ Date: _____

Signature of Member or parent, legal representative
or other (please identify) _____

PEHP Member ID Number: _____

Patient name: _____

Work/home/cell number: _____

Email address: _____

Claim number, PA number, or date(s) of service: _____

Send this form to:
PEHP Appeals and Policy Management Department
PO Box 3836
Salt Lake City, UT 84110-3836

* Be advised, this form only applies if the PEHP Executive Review Committee has denied your appeal and advised in your denial letter that this is your next appeal option. All other requests will be returned to sender. If you have questions, contact PEHP at 801-366-7555.

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