PROVIDER MEDICAL APPEAL FORM

COMMUNITY HEALTH CHOICE

An appeal is a request for Community Health Choice to review a medical necessity denial or adverse determination. Use this form to submit an appeal. **DO NOT use this form to dispute the amount you received for a claim payment or to resubmit a corrected claim.**

TODAY'S DATE: _____ **AUTHORIZATION REFERENCE #:** _____

MEMBER INFORMATION

Member ID Number	Member Name	Member DOB

Address	City, State ZIP

Phone Number	Alternate Phone Number, if any

TYPE OF APPEAL

An **expedited appeal** is when the health plan has to make a decision quickly based on the condition of your patient's health and taking the time for a standard appeal could jeopardize your patient's life, health, or ability to attain, maintain, or regain maximum function.

- ☐ **Standard Appeal**
- ☐ **Expedited Appeal**
- ☐ **IRO (CHIP)**
- ☐ **IRO (Marketplace)**
- ☐ **EMR/State Fair Hearing**
- ☐ **State Fair Hearing**

Briefly describe your appeal:

_____

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PROVIDER INFORMATION

Group/Practice Provider Name	Tax ID

Rendering Provider Name	Rendering Provider NPI

Signature **Date**

Please send completed form and any supporting documentation via mail or fax to:

Community Health Choice
Attention: Appeals Coordinator
4888 Loop Central Dr, Suite 600
Houston, Texas 77081

Fax to: 713.295.7033
Attn: Appeals Coordinator