PacificSource Medicare

PacificSource Community Health Plans, Inc.
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Medicare.PacificSource.com

Provider Appeal Form

IMPORTANT:
Do **NOT** use this form for reconsideration of untimely or duplicate claims, to submit corrected claims, or dispute allowed/contract amounts. Instead, submit those requests via the claims department with explanation/supporting documentation.
Do **NOT** use this form for pre-authorizations denied as "Documentation requested for review not received." Instead, resubmit a pre-authorization request with supporting records to have us conduct a new review.

APPEALS MAY NOT BE REVIEWED IF:

- Appeal form is incomplete (these will be returned for required information).
- Appeal is received by Plan after 60 calendar days of denial date, unless can show good cause for delay in filing.
- No additional information is provided to support further review (i.e. provider believes information was not known or considered in the original decision).
- A non-contracted provider is appealing a claim denial without including a signed Waiver of Liability. The waiver can be downloaded from www.Medicare.PacificSource.com.

Please allow up to 30 days for processing of appeal. An acknowledgment will be faxed to you upon receipt.

Provider Name:	Contact Phone:	
Contact Name:	Contact Fax:	
Member Name:	Member ID #:	
Prior Authorization #:	Claim #:	DOS:

Item/Service/Prescription Appealed: _____

CPT/HCPCS Code: _____

Reason for Denial: _____

For Medicare prior authorization appeals *(please mark if appropriate - do not mark for **claim** appeals):*
☐ I am the member's treating physician, and s/he is aware of/approves filing this appeal on his/her behalf.

For Medicare prescription (Part D) appeals *(please mark if appropriate):*
☐ I am the member's PCP and wrote this prescription.
☐ I am not the member's PCP and wrote this prescription. The member is aware of/approves filing this appeal on his/her behalf.

__REQUIRED__ Reasons for appeal and additional information to consider in the review. We may contact you for more details if unclear or incomplete. Please attach any relevant documentation to support your request:

Send this form to: PacificSource Medicare Provider Appeals, 2965 NE Conners Ave, Bend OR 97701
or via fax to (541) 322-6424.

A health plan with a Medicare contract.