

Provider Appeal Form



Instructions:

- If you are a noncontracted provider, please include a signed Waiver of Liability, available to download from PacSrc.co/med-docs.
- Fill in all fields, and submit within 65 calendar days of denial date.
- Include any new information that was not considered in the original decision.
- Provide single-sided copies, and use paperclips (not staples) to separate documents if submitting multiple services.

When *not* to use this form:

- For reconsideration requests related to untimely, duplicate, or corrected claims—please submit those requests through the Claims department with supporting documentation.
- For prior authorizations denied due to “documentation requested for review not received”—please resubmit those as new authorization requests with supporting documentation.

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

1. Provider information

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 the member is aware of and approves my filing this appeal on their 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 and approves my filing this appeal on their behalf.

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

Check to request an expedited review.

Send this form to: PacificSource Medicare, Attn: Appeals and Grievances
PO Box 7469, Bend, OR 97708 | NewAppeal@PacificSource.com | Fax: 541-322-6424

Questions? Email MedicareCS@PacificSource.com or call **888-863-3637**, TTY: 711. We accept all relay calls.

Coverage provided by PacificSource Community Health Plans.