



An AmeriHealth Mercy Company

ADMINISTRATIVE APPEAL REQUEST

Provider Information:

Date:
Member name:
Member MA ID number:
Provider: Name of person submitting request:
Provider phone number: Type of service:

Please circle the appropriate line of business:

Table with columns: Capital Region, Blair, Franklin/Fulton, Bedford/Somerset, Lycoming/Clinton, Medicare Gateway. Row: HealthChoices

Member's primary insurance Members secondary insurance
Dates of services provider is requesting to be reviewed for CBHNP payment:
Provider's requested action:

Reason for the delay in the authorization:
Steps taken to correct and prevent future occurrences:

REVIEW SECTION:

Supporting narrative to substantiate provider claim: Please submit additional documentation of services rendered, such as EVS verification or other documentation that will support the request. Please include a typed narrative of additional supporting documentation to justify the request

TO BE COMPLETED BY CBHNP Date reviewed by Administrative Appeals Committee:
LOG NUMBER: Claims Submitted: YES NO Eligibility checked:
Sent to clinical reviewer: Date:
Summary to request a clinical review: Authorization dates under appeal:

Date of clinical/Doctor review: Date returned to Appeal Committee:

Outcome: Approval Denial Decision reason:
Final decision date: