Advanced Health
289 LaClair • Coos Bay, OR 97420
Phone 541-269-7400 • Fax 541-269-2052
Toll Free 800-264-0014 • TTY: 877-769-7400

How to Complete
Provider Appeal Request

- All lines of the form must be completed to allow for a thorough review of the disputed claim/authorization.
- All Appeal Requests submitted must include additional information that was not included, previously known or considered by Advanced Health in its decision to deny the claim. If applicable, attach corrected billing form.
- If you have questions regarding this form or a denial reason, please contact Advanced Health Provider Relations at (541) 269-7400. Fax at (541) 269-2052.
- Submit Provider Appeal Request and all additional information to:

Advanced Health – Provider Appeals
289 LaClair Street
Coos Bay, OR 97420

To complete the form, please refer to the instructions below:

Date:	Enter the date the Provider Appeal Request form is filled out
Provider Phone:	Enter the phone number of the contact person at the provider's office
Provider Name:	Enter the name of the provider of service
Contact Person:	Enter the name of the person to contact if additional information is needed
Member Name:	Enter the full name of the Advanced Health Member
Member ID #:	Enter the Advanced Health ID number for the Member
Advanced Health Claim #:	Enter the claim number from the Advanced Health Explanation of Benefits (EOB) that correlates to the claim that is being appealed, if applicable
Date of Service:	Enter the date of service that was denied.
Advanced Health Initial Denial Reason:	Enter the denial reason from Advanced Health EOB
Advanced Health Auth #:	Enter the authorization number for the services that were denied, if applicable
Denied Services:	Enter the billed CPT, HCPCS, or OMAP Unique code number(s) for the services denied and the code description(s)
Reason for Appeal Request and Additional Comments or Information:	Enter reason for the appeal request. Please provide any additional information that was not included, previously known or considered by Advanced Health in its decision to deny the claim.
Follow-Up:	Please call Advanced Health Customer Service for receipt of the appeal and follow up if not resolved in a timely fashion.

Appeal Request #:___________________________________

Advanced Health

289 LaClair • Coos Bay, OR 97420
Phone 541-269-7400 • Fax 541-269-2052
Toll Free 800-264-0014 • TTY: 877-769-7400

Provider Appeal Request

(See "How to Complete Provider Appeal Request" for instructions)

Provider Information:

Date: ____ Provider Phone #: __________________________

Provider Name: ____________________________________ Contact Person: ___________________________

Request is related to the following:

Member Name: ____________________________________ Member ID #: ____________________________

WOAH Claim #: ___________________________________ WOAH Auth #: ____________________________
(if applicable)

Date of Service: __________________________________

WOAH Initial Denial reason: ____

Denied Services: ____

Additional Information:

Reason for Appeal Request and Additional Comments or Information:
____

____

____

Please attach any pertinent clinical information or related documentation that would be of assistance in reviewing this request and to support the reason for reversal of the original denial.

Send completed form and supporting documentation to:

Advanced Health – Provider Appeals
289 LaClair Street
Coos Bay, OR 97420

For Administrative Use Only

Denial Upheld: Yes No

Line Rank(s): _______ _______ _______ ________ _______

Review Results: ____

____