

Provider Appeal/Reconsideration Request

****Chart Notes Required for Preauthorization Denial Appeals/Reconsiderations****

Please fax to 503.765.9675 | Questions call 971.345.5933 or 833.257.2192

SUBMISSION TIME FRAMES:		
Claim Denials: Submission must be received within 60 days from the date of the claim denial.		
Preauthorization Denials: Submission must be received within 60 days from the PA denial.		
If your request does not fall within the time frame, it will not be accepted.		
Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	
Address:		
REQUIRED Contact Information		
Name:	Phone:	Fax:
Requesting Provider:		TIN#:
Servicing Provider:		TIN#:
Servicing Facility:		TIN#:
Reconsideration Request Type:		
<input type="checkbox"/> Preauthorization Denial Preauthorization Date:		
ICD-10 Code(s):	CPT Code(s):	Requested Item/Service:
Reconsideration Request Type:		
<input type="checkbox"/> Claim Denial Claim Number:		
Reconsideration Comments:		

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12/12/2023