Yamhill COMMUNITY CARE

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:

☐ Preauthorization Denial
Preauthorization Date:

ICD-10 Code(s):	CPT Code(s):	Requested Item/Service:

Reconsideration Request Type:

☐ Claim Denial
Claim Number:

Reconsideration Comments:

Provider Appeals have 60 days from date received to resolution.
Please be patient, we will send a fax to you with the results of your request.

IMPORTANT NOTICE: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message. 12/12/2023