

Pre-Certification/Pre-Authorization Appeal Request Form

Date: _____

Case Number: (from denial letter) _____

Appealing Provider

Individual Provider Name: _____

NPI #: _____

Address: _____

Phone: _____

Fax #: _____

Contact name: _____

Contact phone #: _____

Facility/Home Health/Clinic name: _____

Ordering/Attending Provider

(If different than appealing provider)

Provider Name: _____

NPI #: _____

Address: _____

Phone: _____

Fax #: _____

Contact name: _____

Contact phone #: _____

Patient Information

Patient Name: _____

Subscriber Name: _____

DOB: _____

Phone #: _____

ID #: _____

Group #: _____

Procedure/Service(s) being appealed: _____

Diagnosis/ICD-9 Code(s): _____

Procedure codes/ICD/CPT or HCPCS Code(s): _____

Urgent Care

Under federal and state requirements a pre service request is subject to expedited review if it meets the definition of "urgent care":

- In the opinion of the treating physician an expedited review is warranted; or
- Could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function; or
- In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being requested.

Is this request for urgent care? (please check) yes no

Reason for Appeal Request: (Complete description/rationale for appeal) and/or attach letter of appeal, applicable medical records or other supporting documentation.

For prompt processing of your request – please complete ALL fields

Fax form to: 651-662-9517 or Mail form to:
Consumer Service Center, Route P3-2, PO Box 64560, St Paul Minnesota 55164-0560