Health Alliance™

Provider Appeal Form

Date:	Organization or Provider Name:
Contact Name:	Member Name:
Contact Email:	Member ID:
Contact Phone #:	Date(s) of Service:
Portal Inquiry Reference #:	Claim #:

Important Information

All informal provider appeals should be submitted through the online Provider Inquiry Portal located at Provider.HealthAlliance.org. See provider manual for appeals policy.

*Note: Equian, EquiClaim and Cotiviti retrospective audit appeals must be submitted directly to the vendor.

This form is to be used for claim denial appeal requests after you have exhausted all efforts of resolution through the online post-service claim inquiry process for the following reasons **only:**

- Contractual allowances
- Medical necessity
- Clinical editing
- Prior authorization not obtained

If you are not satisfied with the outcome of the online post-service claim inquiry, you may submit an appeal. The purpose of an appeal is to escalate an informal inquiry or bring immediate attention to a critical issue. An appeal should not be the first attempt at communication between the parties for any given issue. You may only appeal for specific reasons outlined in your provider agreement such as contractual allowances, medical necessity, investigational services, clinical editing or no prior authorization.

Appeal Reason

❑ Medical Necessity
- Please include rationale, relevant medical record documentation and InterQual criteria to support medical necessity.

❑ Contractual Allowance
- Please provide the underpayment or overpayment amount and the expected reimbursement.

❑ Clinical Editing
- Please submit documentation or literature from a nationally recognized organization such as National Correct Coding Initiative (NCCI).
  Note: Our code combinations or bundles are performed in our clinical editing system and are supported by nationally recognized criteria.

❑ Prior Authorization Denial

- Please provide a detailed explanation of why prior authorization was not submitted or submit documentation on why authorized procedure was not updated within the 7 day time frame.

❑ Provider Appeal

- Health Alliance Medical Plans must receive the appeal within 90 days from original denial.

❑ Documentation Needed for Appeal

- Appeal form
- An explanation of why you disagree with the claim denial and how you believe Health Alliance should resolve the issue.
- Supporting documentation such as relevant medical records, operative reports and office notes.

Explanation of Dispute

Claim Disputes

Health Alliance Medical Plans has two levels of review when providers appeal a denied claim: provider inquiry and provider appeal.

Step 1: Provider Inquiry Portal – We will attempt to resolve provider-initiated inquiries through the course of normal operational interactions and Health Alliance Medical Plans' informal inquiry resolution process. Providers must initiate informal inquiries within 90 days of the original denial. To clarify, we define provider inquiries as the first contact initiated by the provider to Health Alliance. We accept inquiries through our provider inquiry portal.

Step 2: Provider Appeal – If a provider is dissatisfied with a claims processing or administrative determination and has not found satisfactory resolution through the provider inquiry portal process, the provider may submit an appeal to Health Alliance within 90 days from the original denial.

We define appeals as written provider correspondence about a claim issue previously reviewed through the inquiry process, yet still unresolved to the provider's satisfaction. All appeals must have valid reasons for consideration as stated in your provider agreement. Appealable issues include, but are not limited to, allowances, medical necessity and clinical editing.

Documentation Needed for Appeals

- ❑ Appeal form
- ❑ An explanation of why you disagree with the claim denial and how you believe Health Alliance should resolve the issue.
- ❑ Supporting documentation such as relevant medical records, operative reports and office notes.