

LEVEL ONE NON-PARTICIPATING PROVIDER APPEAL FORM

Note: (Appeal must be filed within 60 days of the initial claim processed date, and must be accompanied by a waiver of liability form. This appeal form is for non-participating providers and facilities only)

SECTION I: MEMBER INFORMATION

MEMBER NAME: _____

MEMBER DOB: _____

PASSPORT ADVANTAGE MEMBER ID NUMBER: _____

SECTION II: REQUESTING PHYSICIAN OR FACILITY INFORMATION (Please Print)

NAME OF REQUESTING PHYSICIAN OR FACILITY: _____

REQUESTING PHYSICIAN OR FACILITY NPI: _____

FAX NUMBER: _____

PHONE NUMBER: _____

OFFICE CONTACT: _____

MAILING ADDRESS (Street or P.O. Box, City, State & Zip Code):

SECTION III: APPEAL INFORMATION

HAS THE CLAIM BEEN FILED FOR THE SERVICE RENDERED? YES NO

(If no, the claim must be submitted before appeals can be considered for the payment of an item or service)

DATE(S) OF SERVICE: _____

DATE(S) OF DENIAL: _____

CLAIM NUMBER: _____

IF YOU RECEIVED YOUR INITIAL CLAIM DETERMINATION NOTICE MORE THAN 60 DAYS AGO, INCLUDE YOUR REASON FOR THE LATE FILING:

Note: (Appeal must be accompanied by a waiver of liability form. This appeal form is for non-participating providers or facilities only. Attach additional pages if necessary.)

I DO NOT AGREE WITH THE DETERMINATION DECISION ON MY CLAIM BECAUSE:

(Attach additional pages if necessary.)

Completed forms accompanied by any supporting documentation should be sent to:

Passport Advantage (HMO SNP)
Attn: Grievance and Appeals
PO BOX 11245
Portland, ME 04104

Or by Fax: 1-888-727-6231

This form is intended for use only when requesting a review for post service appeal requests for claims processed by Passport Advantage (HMO SNP).