Appeal Request

This form is to be used by providers or members to request an appeal.
To initiate the appeal process, complete this form and fax to **(434) 947-4465** or mail to:

Piedmont Community Health Plan, Inc. - Appeals Dept.
2316 Atherholt Road
Lynchburg, Virginia 24501

	Date Completed

Appeal Request Submitted by the:

- ☐ **Member** If additional documentation is needed, we will contact the appropriate parties.
- ☐ **Provider, on their own behalf** PROVIDERS, PLEASE SEND RELATED DOCUMENTATION TO AVOID DELAYS.
- ☐ **Provider, on the member's behalf** PROVIDERS, PLEASE SEND RELATED DOCUMENTATION TO AVOID DELAYS.
- ☐ **Other**:

Submitted By Name:		**Phone:**	
Practice Name: (N/A if not being submitted by a provider's office)		**Fax:**	

This a request to appeal for the following member:

Member Name:			
Member Number:		Member DOB:	

The appeal is regarding the following service/procedure:

Date(s) of Service or Procedure:	
Physician or Facility:	
Claim Number (if available, from EOB):	

The reason for this appeal is: *(check all that apply)*

- ☐ No Preauthorization/referral was requested and received prior to service/procedure
- ☐ Related claims did not pay in-network
- ☐ Related claims did not pay as expected or were denied
- ☐ This is a case of untimely filing (claim filed 60 days after the initial determination) and the reason for the delay in filing is:
- ☐ Other:

Additional Notes or Explanation

Please contact Piedmont Community Health Plan at 434-947-4463, with any questions.

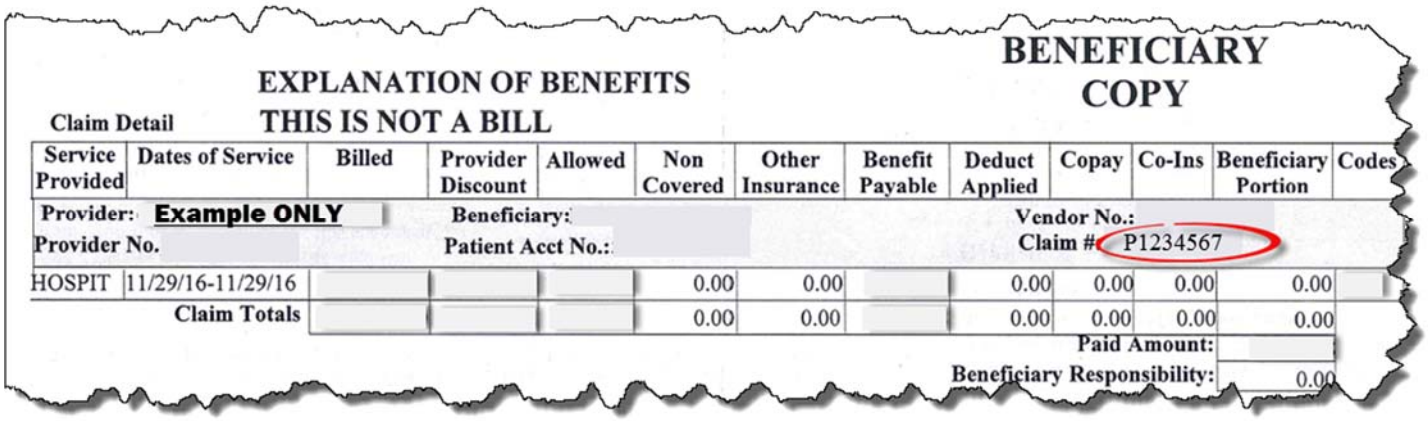
PIEDMONT
COMMUNITY HEALTH PLAN

This page is for reference only and does not need to be sent back to the plan as part of the appeal request.

Where to find the claim number on the EOB (Explanation of Benefits):

The claim number can be found on the EOB on the right, below the "Vendor No.:"

and above the claim payment information.



EXPLANATION OF BENEFITS — **BENEFICIARY COPY**

THIS IS NOT A BILL

Claim Detail

Service Provided	Dates of Service	Billed	Provider Discount	Allowed	Non Covered	Other Insurance	Benefit Payable	Deduct Applied	Copay	Co-Ins	Beneficiary Portion	Codes
Provider: **Example ONLY**			Beneficiary:							Vendor No.:		
Provider No.			Patient Acct No.:							Claim # P1234567		
HOSPIT	11/29/16-11/29/16				0.00	0.00		0.00	0.00	0.00	0.00	
	Claim Totals				0.00	0.00		0.00	0.00	0.00	0.00	

Paid Amount:

Beneficiary Responsibility: 0.00