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 email to Appeals@pchp.net, fax to **(434) 947-4465** or mail to Piedmont Community Health Plan, Inc. - Appeals Dept 1920 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

Should you have questions, please contact Piedmont Community Health Plan at Appeals@pchp.net or (434) 947-4463.

Please copy and reproduce this form as needed for future use with PCHP.

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

<u>Where to find the claim number on the EOB (Explanation of Benefits):</u>

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
THIS IS NOT A BILL

BENEFICIARY COPY

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