QualChoice® HEALTH INSURANCE

Network Provider Appeal Form
Adverse Determination

About Network Provider Appeals

Only denials related to medically necessary, experimental/investigational, lack of pre-authorization (when the amounts are provider liability) or benefit exclusions will be considered in the provider appeal process.

Issues such as timely filing, clinical edits, coding disputes, contractual reimbursement, etc., will be handled through the Provider Reconsideration Process.

Appeal requests must be received on the *Network Provider Appeal Form* within the timeframe outlined in your provider agreement. The request must be completed in its entirety and include QualChoice provider number, date(s) of service, claim number(s), reason for the appeal and any written comments, documents, records or other information relating to the case.

The Plan's decision is due within 30 calendar days from the receipt of the appeal request.

Please select the reason the claim or service was denied.

- ☐ Not Medically Necessary
- ☐ Experimental/Investigational
- ☐ Lack of Pre-authorization
- ☐ Benefit Maximum Exhausted
- ☐ Benefit Exclusion

Section I: Provider Information			
Provider Name	National Provider Identifier # (NPI)	QualChoice Provider Number	
Street Address	City	State	Zip
Telephone Number	Fax Number	Contact Name	Contact Email Address
Section II: Patient Information			
Last Name	First Name		
Member Identification Number	Date of Birth (MM/DD/YYYY)		
Section III: Claim Information [Copy of claim(s) or Remittance Advice(s) are required.]			
Claim Number	Date(s) of Services (MM/DD/YYYY) From To		
Section IV: Appeal Explanation			

Instructions

A Network Provider may request an appeal once notification of an adverse determination has been received. This form may be used for appeals that relate to authorization or pre-certification problems that affected payment, benefit exclusions, claims or services that have denied for "not medically necessary" or "service is experimental or investigational in nature."

1. Complete the form in its entirety.
2. Describe the issue that affected your claim payment in as much detail as possible.
3. Review that all of the information is correct **and** the required information is included.

Mail form and attachments to:

QualChoice Health Insurance
P.O. Box 25610
Little Rock, AR 72221
Attn: Grievance & Appeals

Or fax form and attachments to:

833.681.2498

Coding disputes, contractual reimbursements, etc., are **not** eligible for the provider appeal process and are handled through the Provider Reconsideration Process.

For questions, please contact our Customer Service Department at 800.235.7111 or 501.228.7111.