PacificSource HEALTH PLANS

Provider Appeal Form

Please review the following requirements for submitting this appeal:

- All of the information requested in this form is needed for the consideration of your appeal; an incomplete form or an appeal with missing information will be returned.
- Do **not** use this form for duplicate or corrected claims. Instead, submit those requests to the **PacificSource Claims Department** with an explanation and supporting documentation.
- This appeal needs to be received within 180 days after the denial, unless you've provided good cause for the delay.
- A second attempt for a denied appeal won't be reviewed.
- If you're including supporting documents, please enclose only single-sided copies.

Member Information

Provider name _____ Provider NPI _____

Contact name _____ Phone _____ Fax _____

Member name _____ Member ID # _____

Authorization/referral # _____ Claim # _____ DOS _____

Appeal Information

Item/Service/Prescription appealed _____

CPT/HCPCS/CDT codes appealed _____

☐ I am requesting an expedited appeal (i.e., resolution within 72 hours of receipt) and understand that support indicating a 30-day wait for a decision may be a health risk to the member is required.

Please describe your appeal request and attach all relevant information and documentation that supports your request. Missing, incomplete, or unclear information is likely to delay the appeal process.

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Mail or fax this form to:
PacificSource Health Plans Appeal and Grievance Department, P.O. Box 7068, Springfield, OR 97475-0068
Fax: (541) 225-3628