PeakHealth
MEDICARE PLANS

Peak Health Medicare Plans Provider Complaint and Appeal Form

Please provide the information below for the member.

Member ID Number:		**Member Group Number (Optional):**
Member Last Name:	**Member First Name:**	**Member Date of Birth (MM/DD/YYYY):**

Provider Name:	**TIN/ NPI:**	**Provider Group (if applicable):**
Contact Name and Title:		
Contact address (Where appeal or Compliant resolution should be sent):		
Contact Phone Number:	**Contact Fax Number:**	**Contact Email Address:**

Please advise if appeal is related to: Pre-Service Post Service

Are you requesting an expedited review: Yes No

To allow us to review and respond to your request, please provide the following information.

If you are a non-contracted provider, please submit a completed waiver of liability statement.

Reference Number	**Service Date (if service already provided):**	**Date of Denial (if applicable):**

CPT/HCPC/Service(s) and/or Drug(s) being appealed or disputed (for drugs, please provide specific strengths, dosing, and quantities requested):

Explanation of your request or why you disagree with the decision: (Please use additional pages if necessary.)

Note: When submitting this form please include any supporting documentation that would be helpful in the review of your request including invoices, correspondence, medical records, or other clinical documents.

You may upload this form or any supporting documentation electronically via Epic, Epic Link CRM function, or the PeakProvider Secure Portal.

You may also submit your request by fax or by mail:

Peak Health Appeals and Grievances Department

1085 Van Voorhis Rd, Suite 300

Morgantown, WV 26505

Fax: 304-974-3470

If requesting an expedited review or for assistance with completing this form, please contact Peak Health Provider Service at 1-855-962-7325(TTY: 711), Hours from October 1 to March 31: 8 a.m. to 8 p.m., 7 days a week. Hours from April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

Signature: _____**Date:** _____

Waiver of Liability Statement

Enrollee's Name	Enrollee ID Number
Provider	Dates of Service

Peak Health Medicare Plans

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date