PeakHealth

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 the 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.

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

P.O. Box 4262

Morgantown, WV 26504

Fax: 304-974-3191

If requesting an expedited review or for assistance with completing this form, please contact Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325), Monday through Friday, 8:00am to 5:00pm ET, excluding holidays.

Signature: _____ **Date:** _____