289 LaClair St. | Coos Bay, OR 97420
Main: 541-269-7400 | Fax: 541-269-7147
Toll Free: 800-264-0014 | TTY: 711 or 800-735-1232
www.advancedhealth.com

Provider Reconsideration Request Form (Provider Auth Appeal)

Please include a copy of the denial notice and detailed justification for the re-determination of the denial.
Advanced Health accepts Provider Reconsideration Requests up to **60 days** from the date of denial.
For denials outside of 60 days, or denials of "Information not Received", please submit a new auth request.
Retroactive Prior Authorization Requests are accepted up to **90 days** from Date of Service (see back page).
Providers may also request a Peer to Peer by calling ext. 203.
To submit an appeal, you may fax or mail:

- This completed form and a copy of the denial notice, OR
- Submit a provider-dictated letter of dispute and a copy of the denial notice.
- DO NOT submit a copy of the same documentation included in the prior authorization with a note to "please reconsider". These requests will receive a dismissal letter.

Date: _____

Provider Name: _____ Contact Name: _____

Fax Number: _____ Contact Phone Number: _____

Member Name: _____

Member OHP ID: _____ Member DOB: _____

Denied Authorization #: _____
(Advanced Health Document ID or submit a copy of the denial notice with this form)

Service(s), Item, or RX Denied: _____

Advanced Health Reason for Denial: _____

Provider Reason for Reconsideration (If you need additional space, please use the last field of this form):

☐ A below-the-line condition/treatment pair is justified under the co-morbid rule OAR 410-141-0480(8), or Special Health Care Needs OAR's 410-141-3865 and 410-141-3870.

- Co-morbid Diagnosis: _____
- SHCN or Circumstances: _____

☐ A treatment that is part of a covered complex procedure and/or related to an existing funded condition.

- Explain: _____

☐ Non-Covered Service

- Exception Rationale: _____

☐ Medical documentation of applicable evidence-based practice literature that is consistent with the condition or service under review.

- Source: _____

☐ Additional information to meet criteria in OHP Prioritized List Guideline Note listed in the denial notice.https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Searchable-List.aspx

☐ Additional information to meet OHA, or Advanced Health, Drug Use Criteria listed in the denial notice. https://advancedhealth.com/providers/pharmacy-info/

☐ Not Medically Appropriate. Please respond to specific notations listed in denial notice.

Identify NEW information included

- New/Amended/Updated Note(s) or Treatment Plan Dated: _____
- Physical Exam Office Visit Note(s) Dated: _____
- Medication trial and failures with Name, Dates, and Strengths: _____
- Lab, Imaging, or other test results:

☐ PFT/Spirometry ☐ MRI ☐ CT ☐ Xray ☐ Nicotine ☐ BP ☐ A1c ☐ CBC ☐ CMP
☐ Iron Study ☐ Liver Function ☐ Renal Function ☐ %Weight Loss/Gain

☐ Other: _____

☐ A service that should be covered where denial was due to technical errors.

Explain: _____

☐ Other/Continued/Additional Info:

Please attach any pertinent clinical information and related documentation that will be of assistance in reviewing this request. Send only documentation to support the reason for reversal of the original denial. For denials, two reviewers already looked at the authorization request. Advanced Health policy is that only a Pharm D, MD, or LCSW can make an authorization denial. Medical Management staff are qualified to make allowable limit adjustments and will seek appropriate clinical guidance when necessary.

Retroactive Prior Authorization Requests are accepted up to 90 days from Date of Service. Please use the *Physician Authorization Referral Form* under the provider forms and resources tab on our website. https://advancedhealth.com/providers/resources/ See OAR 410-120-1320 for more information.

A complete auth request includes ALL of the following:

- Patient Name, Date of Birth, Member ID#
- Name of Requesting Provider
- Name of Referred to Provider (Performing Provider)
- Primary Diagnosis Code(s)
- Procedure Code(s)
- Chart Notes Attached
- Date(s) of Service (if retroactive request)