Claim Review Request Form

If a member submits a claim for coverage and it is initially denied under the procedures described within the group plan document, that member may request a review of the denial. Prodegi `allows 180 days after a member receives notice of an initial adverse determination to request a review of the adverse determination.

Member Information			
Member Name		Member ID	
Patient Name		Employer Name or Group Number	
Address	City	State	Zip code
Phone number		Email address	

Your status:

☐Enrollee/Patient ☐Provider

☐Legal representative, e.g., Power of Attorney, Legal Guardian, Executor or Personal Representative of the Estate (if you are any of these, please attach proof of such)

☐Authorized representative (If you are appealing for someone other than yourself, such as your spouse, a child (18 years of age or older) or another adult age 18 or over, please complete the: 1) Authorized Representative Form, or a 2) HIPAA Authorization to Release PHI. You do not need to complete both forms.

The HIPAA Authorization to Release PHI and the Authorized Representative Form can be found at ProdegiBenefits.com under Forms.

Claim Information			
Document Number	Date of Service	Document Number	Date of Service
Document Number	Date of Service	Document Number	Date of Service

☐First Level Appeal ☐Second Level Appeal ☐Pre-Service Appeal

Appeal Reason

Please describe in your own words, why you disagree with the determination on the claim(s):

Attach additional sheets if needed. Supporting documents may be necessary for review, such as an operative report for a review of surgery charges. Please send copies of documents that support your appeal, such as physicians' letters, operative reports, bills, medical records and Explanation of Benefits (EOB) forms. The review may be delayed if supporting documents must be requested by Prodegi.

☐Please provide copies of information relevant to the claim with the appeal response.

I confirm that the above information is correct.

Signature: _____ Date: _____

Relationship to patient: _____
(e.g., parent, legal guardian, medical power of attorney, appeals authorized representative)

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