SmartHealth®

Pre-service and 1st level appeal request form

If you are a member submitting an appeal, please complete the information below and include any additional medical records or documentation to support your appeal.

Please complete the following information:

Appeal is being filed by: Member ☐ Physician ☐ Facility ☐ Other representative ☐

If other representative is selected, please indicate relationship to member and include a signed personal representative form or your appeal will be returned:

Today's date	***Group name***	
Member's first name	***Member's last name***	***Member's ID number***
Address of Member		
Patient's first name	***Patient's last name***	***Patient's date of birth***
Name of provider	***Provider's TIN/NPI***	***Provider's phone number***
Address of provider		
Authorization Number	**Provider fax number**	
CPT/HCPCS/Service being disputed		
Explanation of your request (please submit additional pages if necessary)		

Please fax or email your *pre-service* appeal or 1st level appeal with this form to: 586-693-4768 .
You may also mail your pre-service appeal to: SmartHealth Appeals, 1345 Philomena St. Suite 305, Austin TX 78723.

Ascension