SmartHealth

Post Service and 2ND 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. If you have a copy of the claim or the Explanation of Benefits (EOB) please include a copy with your submission. If you are a provider submitting a claim on behalf of a member, please include a copy of the EOB, a copy of the claim and any/all medical records and/or documentation to support your request for the appeal.

January 1st 2020 Notification: Do not use this form for prior authorization denials received after 1/1/20 from EQHealth. All appeals relating to the first level prior authorization requests for services starting 1/1/20 must be submitted directly to EQHealth. Please refer to the denial letter you received for information on where to submit 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:

_____

Today's Date	*Group Name*

Member's First Name	*Member's Last Name*	*Member's ID number*
Patient's First Name	*Patient's Last Name*	*Patient's Date of Birth*
Name of Provider	*Provider's TIN/NPI*	*Provider's Phone Number*

Claim Number	*Claim Date of Service*

CPT/HCPCS/Service Being Disputed
Explanation of your request (please submit additional pages if necessary)

Please fax your *Post Service* appeal or 2nd Level Appeal with this form to: 586-238-4363
You may also mail your post service appeal to: Appeals Department, PO Box 321125, Detroit MI 48232

Ascension