SARASOTA MEMORIAL HEALTH CARE SYSTEM

CHARTER HEALTH PLAN

A big idea for small business

Claims Appeals Form

To be completed by Charter Health Plan Member or Health Services Provider.

Date of Service: _____
Date of Denial: _____
Date of Appeal: _____
Member ID Number: _____
Patient Name:
Last: _____ First: _____ Middle Initial: _____ Age: _____ Sex: _____
Primary Care Physician: _____
Specialty Physician (if applicable): _____ PCP Referral #:_____
Person Requesting the Appeal: _____

Procedure/Test Requested: _____

Was procedure/test performed in the Primary Care Physician's office?	Yes	No
Patient went to lab for the procedure/test?	Yes	No
Specimen was sent to lab by physician's office?	Yes	No

Diagnosis: _____
Complicating Conditions/Mitigating Circumstances:
_____

Check one of the following: Emergent* ☐ Non-Emergent ☐
*If Emergent – Please supply clinical data to support emergent determination.
Reason for Initial Denial:
_____
_____

Reason for Appeal – Must specifically address the reason for initial denial and must provide additional information to support an overturn in the initial denial decision.
_____
_____
_____

Attach copies of all supportive data (i.e. CT scans, biopsy reports, specialty notes, referral forms, EOBs, authorization numbers, bills, etc.) and any pertinent clinical data to support the appeal.
Note: All non-emergent services provided out of the Network will be denied and the denial supported, unless prior authorization was obtained.

Please send this **completed** form to:
Charter Health Plan
c/o RN Case Manager
1991 Main Street, Suite 147
Sarasota, FL 34236
Please call (941) 917-8500 if you have any questions on completing this form