Level I provider appeal form

This form is for out-of-network provider use. Providers participating with Priority Health must submit appeals in prism, our online provider portal. Out-of-network providers may also use prism for faster response. (Note: All Level 2 medical necessity appeals must be submitted in prism.)

Using this form	Medical necessity (authorization) appeals	Claim appeals
When to use this form	When appealing an authorization / medical necessity decision	When appealing a medical or behavioral health claim decision, after receiving a response on an Informal Claim Review. Providers have one claim appeal right.
Deadline	Within 65 days of the authorization denial notice	Within 180 days of the first remittance advice
Additional documentation	• New clinical documentation • Priority Health denial letter	All pertinent supporting documentation must be attached (i.e., office notes, radiology and lab / pathology reports, operative notes, etc.)
How to submit	• Behavioral Health: 616.975.0249 (fax) • All others: 616.464.7500 (fax)	Priority Health Appeals Analyst 1231 East Beltline NE Grand Rapids, MI 49525

Submitter contact information

Provider/facility name	Tax ID	Contact name
Phone	**Fax**	**Email**
Address		

Member information

Member last name	Member first name
Member ID number	**Member date of birth**

Claim information (if a claim is on file)

Claim number	Date(s) of service(s)	Total charge(s)
Inquiry number	**Disputed codes**	

Authorization information (for authorization appeals only)

Authorization number	Disputed dates of service

Explanation of appeal

Include the denial reason. An attached denial letter and new clinical documentation are required for authorization and related readmission appeals. If appropriate documentation isn't provided, the appeal won't be reviewed.