Provider Appeal Request Instructions

BEFORE PROCEEDING, NOTE THE FOLLOWING

- Corrected claims should be submitted to the claim's address on the back of the member's ID card. If you are submitting additional information for the initial review of payment, please forward to the claim address on the back of the member's ID card.
- Fee Schedule or reimbursement terms for multiple patients do not require individual appeals. If you are a contracted provider and feel your contract is being inappropriately applied, please contact your Provider Relations Representative or email providerrelations@alliantplans.com.

Step 1: Contact Alliant's Customer Service department at 800-811-4793 to review adverse coverage determinations and/or payment reductions. We may be able to resolve your issue outside of the formal appeal process. If a Customer Service Representative cannot resolve the initial coverage decision, they will advise you of your right to request an appeal.

Step 2: Complete and mail this form and/or appeal letter along with any supporting documentation to the address at the bottom of the Provider Appeal Form. By providing complete and accurate information, we can perform a timely and thorough review. If assistance is needed in preparing your appeal, you can contact Customer Service. Your appeal should be submitted within 180 calendar days from the date of the initial Explanation of Payment (EOP). You will receive a decision in writing.

REQUEST FOR AN APPEAL SHOULD INCLUDE:

1. A copy of the original claim and Explanation of Payment (EOP), or First Level Appeal decision letter, if applicable.
2. For adverse decisions involving a previous clinical denial, (e.g., denied days, level of care, medical necessity, or failure to obtain prior authorization) supporting documentation should include a narrative describing the situation, an operative report and medical records.

If you submit a letter in place of the Provider Appeal Form, please specify in your letter this is a **Provider Appeal**. Please include all the information requested on the Provider Appeal Form.

PROVIDER APPEAL FORM

DATE REQUESTED: MM/DD/YYYY

PROVIDER INFORMATION

Provider / Group Name:		Tax ID Number:
NPI Number:		Contact Name:
Contact Phone Number:	Contact Fax Number:	Contact Address:

SUBSCRIBER INFORMATION

Subscriber Name:	Subscriber ID:
Patient Name *(as shown ID card):*	Patient Date of Birth: MM/DD/YYYY

APPEAL INFORMATION

Type of Appeal *(Check one)*: ☐ Medical Appeal ☐ Claim Appeal

Level of Appeal *(Check one)*: ☐ First Level Appeal ☐ Second Level Appeal

Claim Number:	Date of Service: MM/DD/YYYY	Amount Billed: $

Explain reason for appeal request (If space is insufficient, please attach additional documents):

Note: Supporting documentation is required for Appeal Review. *(See instructions)*

IMPORTANT INFORMATION

- First Level appeals must be submitted within 180 days from the date of the EOP.
- Second Level appeals must be submitted within 60 days from date of First Level Appeal decision letter.

To file claim appeals, please submit this form and supporting documentation to one of the following:

Mail: Alliant Health Plans, Inc.
Appeals Department
P.O. Box 1247
Dalton, GA 30722

Fax: (866) 634-8917

To file medical appeals (including when a service has not been rendered, i.e., UM appeals), please submit this form and supporting documentation to one of the following:

Mail: Alliant Health Plans, Inc.
Appeals Department
P.O. Box 1247
Dalton, GA 30722

Fax: (866) 370-5667

Note: This form is intended for internal reviews only. For information regarding external appeals, please refer to your Certificate of Coverage or contact Customer Service at (800) 811-4793.