NHealth
Norman Regional Health System

NHealth
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Care Coordination Appeals Form

It is understood that the Employer retains full and final authority and responsibility for its Self-funded employee medical plan and its operation. The purpose of this form is to request a reconsideration of a denied referral request for members enrolled into the Care Coordination Benefit Plan. Please complete the form in its entirety and return to the Care Coordination office for further evaluation.

Be Sure to Include:

1. **Completed Appeals Form**
2. **Original Referral Request**
3. **Any Supplementary Documentation that Supports the Medical Necessity of Services Needed**

Employer Name:	**Referring Physician Name/Tax ID #:**
Employer Group Number:	**Referring Office Phone:**
Employee/Dependent Name	**Referring Office Fax:**
Employee ID:	

Please present clinical information that supports the medical necessity of the services needed in the space below. List only 1 appeal per form, and if additional space is needed provide attached documentation. Full review of the appeal request may include peer-to-peer counseling between the Care Coordination Medical Director and the referring provider. You will receive a decision within 5-7 business days and all decision post appeal will be final:

Provider Signature: _____ Date: _____

NHealth Care Coordination Office Use Only

Approved: _____ Date: _____

Denied: _____ Date: _____

Reason: _____

Peer-to-peer Date: _____