Adverse Determination Appeal Request Form

Use this form when service is denied, reduced, or terminated for reasons related to medical necessity or when appropriateness of service is called Adverse Determination. Please do not submit new claim submissions, corrected claims, or itemized bills with this form. Directions are on the EOB/EOP.

Please select the appropriate type of provider and product:

Provider: ☐ Physician ☐ Hospital ☐ Lab ☐ DME ☐ Other:

Product: ☐ Commercial ☐ Medicare Advantage: *Non-contracted providers must submit a WOL form*

Member information:

Member ID:	Referral#/Claim#:	Date of Service:	Billed Amount:
Member Name: Last		First	MI
Street Address		State	Zip

Physician/health care professional information:

Tax Identification Number (TIN):	Phone Number:	Email address:

Physician Information (as listed on Provider Remittance Advice):

Last	First	MI
Street Address	State	Zip
Facility/Group Name	Contact Person:	

Reason for Appeal:

- ☐ Denied Inpatient Days **include medical records*
- ☐ No Precertification/Prior-Authorization **documentation must explain why authorization guidelines were not followed*
- ☐ Not a covered benefit/Policy Exclusion **documentation to support medical necessity*
- ☐ Other:

*Required attachments: Copy of Provider Remittance Advice and Explanation of Benefits. Other required documentation as listed above. Form must be submitted with all appeal requests.

Additional comments:

Please submit this form and supporting documentation to:

Memorial Hermann Health Plan
Attn: Appeals and Grievance Department
P.O. Box 19909
Houston, TX 77224
Fax: 713.704.0884

FORM ID: MHHP-AG-001

MEMORIAL HERMANN Health Plan