Provider Appeals Review Form

Please utilize this form to request an appeal of a claim payment denial for covered services that were medically necessary. Matters addressed via this form will be acknowledged as requests for an appeal.

Appeals must be submitted within 180 days of the original claim denial.

PLEASE DO NOT SIMPLY ATTACH A COPY OF THE ORIGINAL CLAIM
MEDICAL RECORDS SUPPORTING SERVICES BILLED WILL BE REQUIRED
BEFORE AN APPEAL IS REVIEWED

🡻 All fields in the box immediately below are required information.

Date of Request: _____

Provider Name: _____

Provider Number: _____

Claim Number: _____ Date(s): _____

Member Name: _____

Member Number: _____

Reason for Appeal Request:

☐ Services are covered and were medically necessary

☐ Denied for no authorization; authorization # _____ obtained

☐ Other (please explain below)

_____

_____

_____

_____

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Note: If the claim requires a correction, such as a valid procedure code, location code, or modifier, please send request to our claims payment department (address and details are located on Buckeye Health Plan website – Provider Resources tab.

Mail completed form(s) and Medical Records to:

Buckeye Health Plan
4349 Easton Way, Ste. 300
Columbus, OH 43219

A photocopy of this form is permissible.