Request for Internal Appeal Form

Providence Health Plan | POWERED BY Collective Health

You have the right to appeal adverse benefit determinations. These may include:

- Determinations of ineligibility to participate in the plan
- Determinations that certain services are not covered
- Rescission of coverage
- Determinations that certain treatments are not medically necessary
- Termination of your membership in this plan

You must submit your appeal within 180 days of the adverse benefit determination.

Patient Information

Patient Name _____ Patient DOB _____

Subscriber Name _____ Subscriber ID _____

Services in dispute

Claim Number (if applicable) _____ ◯ Yes When: _____ ◯ No

Have you already received these services?

Provider Name _____ Provider Address _____

Please state the reason you believe the decision was incorrect (you may also attach a letter of explanation):

In addition to this form, please submit any additional supporting documentation. This may include:

- A letter or prescription from your doctor
- A receipt for money you paid
- Relevant excerpts of medical records

Signature _____ Date (mm/dd/yyyy) _____

I am the: ◯ Patient/Subscriber ◯ Parent/Legal Guardian ◯ Authorized Representation

*If you are a third party, a provider, or you are submitting this on behalf of a family member for whom you do not have full PHI authorization, please also fill out the appointment of authorized representative form attached.