Clinical Authorization Appeal Form

Attn: Provider Appeals
Fax: 567-585-9500
Standard Mail: Paramount P.O. Box 497 Toledo, OH 43697-0497

Contracted providers are subject to Appeal Timely Filing contract language. Non-Contracted Providers are subject to the UCM Default of (60) calendar days for Appeal Timely Filing in accordance OAC 5160-26.08.4(D)(1) and CMS Chapter 13 Section 50.1

Provider Name		**NPI Number**	
Provider Billing Tax ID Number (TIN)		**Phone Number**	
Contact Name		**Fax Number**	
Date of Request		**Place of Service**	
Member Name		**Member Date of Birth**	
Member ID Number		**Claim Number**	
Date of Service		**Authorization Reference Number**	
Billed Amount		**Denied Explain Code**	

(Mandatory) Please select the specific product line and appeal type listed below

ELITE ☐

☐ Contracted Provider

COMMERCIAL/HMO ☐

☐ Non-Contracted Provider

Readmission Check if applicable (526)	**Retro Authorization** Check if applicable (527) ☐
Authorization Adverse Clinical Determination Check if applicable ☐	Please provide discharge summary from previous admission and clinical information supporting your request. **DO NOT SEND ENTIRE INPATIENT MEDICAL RECORD**
If you selected **Authorization Adverse Clinical Determination**; please indicate the type of authorization denial as listed below (Only Select One)	Please provide confirmation of your fax request sent in a timely manner, documentation showing the member presented as self-pay, AND/OR Other insurance

☐ HHC (539)	☐ Skilled Nursing Facility (543)	☐ Out of Plan (542)	ENTER RATIONALE FOR APPEAL HERE:
☐ Drug on Medical Claim (115)	☐ Genetic Testing (536)	☐ LTAC/Rehab (543)	
☐ Imaging (540)	☐ Medical/ Surgical (536)	☐ DME (538)	
☐ Inpatient (543)	☐ Behavioral Health (535)	☐ Other (87)	

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