



## APPEAL REQUEST FORM

This form is used to request healthcare appeal services from **ClearPath Appeals**. Please complete all applicable sections and submit using a HIPAA-compliant method.

### SECTION 1: APPEAL REQUEST TYPE

- Medical Necessity Denial  Prior Authorization Denial  Coding/Modifier Denial  
 Timely Filing Denial  Duplicate Claim Denial  Non-Covered Service Denial  
 Lack of Clinical Documentation Denial  Other \_\_\_\_\_

### SECTION 2: PATIENT & CLAIM INFORMATION

Patient Name:

Date of Birth:

Insurance Plan / Payer:

Member ID:

Date(s) of Service:

Claim Number (if available):

### SECTION 3: DENIAL INFORMATION

Date of Denial:

Denial Reason (as stated by payer):

### SECTION: 4 DOCUMENTS SUBMITTED

- Medical Records  Physician Orders  Operative Reports  Discharge Summaries  Progress Notes  
 Clinical Guidelines  Denial Letter  Claim Form  Other \_\_\_\_\_

By submitting this Appeal Request Form, the provider acknowledges and agrees that Appeal outcomes are determined by payers and **payment is not guaranteed**.

Provider Representative: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_