Provider Appeal/Grievance Request Form
Commercial

MAIL TO:

Coventry Health Care of Delaware, Inc.
Attn: Appeals Coordinator
750 Prides Crossing
Suite 300
Newark, De 19713

Providers Name: _____
Providers Address: _____
Contact Name: _____
Phone Number:_____

Please indicate your type of Appeal below:

☐ **Clinical Appeal/Grievance** - Check this box for a denial of services that you believe were based in whole or in part of clinical judgment such as:

- Per the Delaware State Regulations, Delaware Providers may only appeal as an authorized representative on behalf of the member unless your contract with Coventry Health Care of Delaware, Inc. specifies otherwise. A completed HIPAA form will be required when Delaware Providers submit an appeal on behalf of a member.
- Medical Necessity denials
- Cosmetic procedure denials
- Experimental / Investigational procedure denials
- Inpatient level of care issues
- Emergency room services

☐ **Administrative Appeal/Grievance** - Check this box for a denial you believe was based on non-clinical issues:

- Per the Delaware State Regulations, Delaware Providers may only appeal as an authorized representative on behalf of the member, unless your contract with Coventry Health Care of Delaware, Inc. specifies otherwise. A completed HIPAA form will be required when Delaware Providers submit an appeal on behalf of a member.
- Benefit determination denials
- Member eligibility post service denials
- Untimely filing denials
- Denials for no authorizations

☐ **Claim Payment Disputes** – Check this box for denial of services which may include, but are not limited to, claim check edits, the use of modifiers, duplicate claims, assistant surgeon billing, global or incidental codes, etc.

PLEASE NOTE: DISPUTES OF THIS NATURE SHOULD BE SUBMITTED TO THE FOLLOWING ADDRESS AND NOT TO THE WILMINGTON, DE OFFICE:

Coventry Health Care of Delaware, Inc.
P.O. Box 7713
London, KY 40742

Member Name_____ Member ID Number_____
Date(s) of Service Denied:_____

Please use the space below to supply any other necessary information, along with your attachment (s), to enable a thorough Appeal/Grievance review.

_____

_____

_____

_____

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_____

Signature of Sender_____ Date_____

Member Name: _____
Member ID # : _____
Dates of Service: _____

Dear Provider,

You recently contacted us, to request an appeal of an adverse benefit determination Coventry Health Care of Delaware Inc. (CHCDE) made related to the above referenced member. In order for you to appeal on behalf of the member, CHCDE is required to receive written or verbal authorization from the member that you are the member's authorized representative with regard to this matter.

Therefore, we ask that you and the member complete the enclosed authorized representative form and return it to us within 10 days of receipt of the form. Upon receipt of the completed form, we will initiate a review of your appeal. If the completed form is not received within 30 days of this letter, we will consider your request for an appeal as withdrawn. You may send or fax the form to us at:

Coventry Health Care of Delaware, Inc.
ATTN: Appeals Coordinator
750 Prides Crossing, Suite 300
Newark, DE 19713
Fax: (866) 889-7559

The member may also call the Appeals Department at (800) 727-9951 and verbally authorize you to act as his/her Authorized Representative.

If you or the Member has any questions, please feel free to call me at number listed above.

Sincerely,

Appeals Coordinator

Coventry Health Care Of Delaware, Inc.
Authorization For Disclosure Of Personal Health Information To Appeals Representative

The following person will act on my behalf during appeals related to _____ (please provide a brief description of the issue that will be appealed).

Name of person acting on my behalf: _____
Address of person acting on my behalf: _____
_____

Telephone number of person acting on my behalf: _____

I understand that:

- I may revoke this authorization at any time by sending Coventry Health Care of Delaware, Inc. written notification of my revocation;
- Revocation of this authorization will not affect any action Coventry Health Care of Delaware, Inc. took in reliance on this authorization before it received my written revocation;
- This authorization will expire upon the completion of the appeals process;
- **Coventry Health Care of Delaware, Inc. may need to provide my representative with my health information, which may include my protected health information (PHI), so that my authorized representative can participate in the appeals process.**

By signing below, I acknowledge that I have read and understand the information above.

Member Name: _____(please print name) Date _____

Member signature:_____ Member ID Number: _____