Expedited Appeal Form

Is the appeal for a service that the patient has not yet received? _____ Yes _____ No

If "Yes", continue with this form. If "No", then use the standard appeal process.

The preferred method of submission is to submit all appeals through the HAP CareSource Provider Portal, however, if you are unable to do so, please complete the following form and submit to the mailing address below.

PATIENT INFORMATION

DATE OF SERVICE: _____ AUTHORIZATION NUMBER: _____

NAME: _____ DATE OF BIRTH:_____

HAP CARESOURCE ID NUMBER: _____

PROVIDER INFORMATION

PROVIDER NPI: _____ PROVIDER TAX ID Number: _____

PROVIDER NAME: _____ REQUESTOR NAME: _____

REQUESTOR EMAIL: _____ REQUESTOR PHONE: _____

REQUESTOR ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: __EMAIL __PHONE __POSTAL MAIL

SERVICE INFORMATION

What service denial is being appealed:_____

_____

Explain why this service is needed and why the standard appeal process will harm the patient:

_____

_____

_____

I certify delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health, or ability to regain maximum function, cause a significant negative change in their medical condition, or subject the patient to severe pain that cannot be adequately managed without the requested service.

Provider's Signature: _____ *Date:* ____/____/_____

Printed Name: _____

For any questions, please call 1-833-230-2102 from Monday to Friday from 7 a.m. to 8 p.m. Eastern Time (ET)**.**

HAP CareSource Grievance & Appeals Department Address: P.O. Box 1025, Dayton, OH 45401

- *When submitting the form, include documentation which supports the appeal, including but not limited all medical records that will need to be reviewed.*
- *If an incomplete appeal is submitted, the provider will receive a notification indicating the request is incomplete.*

MI-MED-P-2194753