PROVIDER APPEAL FORM

Use this form as part of the Western Sky Community Care Healthplan Appeal process to address the decision made during the request for review process. **This form should be utilized if a claim has been processed and a Medicaid Remittance Advice issued from Western Sky Community Care Healthplan. Do not use for first time claims or corrected claims.** For corrected claims, please use the claims resubmission process outlined in the provider billing manual.

All claim requests for claim disputes must be received within 60 calendar days from the date of the Medicaid Remittance. All fields below are required information. Failure to complete the form may result in a delay of your request.

An appeal is a request for Western Sky Community Care Healthplan to review a claim with additional information submitted by the provider that may not have been previously submitted. Supporting documentation for review include, but is not limited to:

- Copy of Invoice for Pricing Review
- Additional documentation which would clarify services

An Appeal is a formal written request to Western Sky Community Care Healthplan for review of a claims payment or Utilization Management decision. Types of denials that would be an appeal include but are not limited to:

- Precertification (UM decision)
- Experimental/Investigational (UM decision)
- Medically Necessary/Level of Care (UM decision)
- Claim did not pay as expected (claims)
- Untimely filing (claims)

Please check the appropriate box below.

☐ CLAIM APPEAL: The attached claim(s) was originally submitted with incorrect/insufficient information.

☐ UM DECISION APPEAL: Must include medical records or medical information.

Please include relevant claim information and any supporting medical or clinical documentation with this form and mail to the following address:

Western Sky Community Care Healthplan
P.O. Box 5090
Farmington, MO 63640-5090

Member's Name:	Member's Medicaid Number:
Date(s) of Service:	Control/Claim Number(s):
Medicaid Remittance Date:	Billed Charge(s):
Provider Name:	Provider TIN Number:
Medicaid Provider Number:	Provider Contact Number:
Contact Name:	Contact Address:

Western Sky Community Care Healthplan will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision) or overturn our original decision (if we overturn our original decision, we will send you a letter stating our decision and any additional payment due will appear on the provider remittance.)

This form may be photocopied