EVERNORTH
HEALTH SERVICES

Evernorth Behavioral Health
Central Appeals Unit
P.O. Box 188064
Chattanooga, TN 37422
www.Evernorth.com

Guide for Requesting an Appeal

An appeal is a request to change a previous adverse decision made by Evernorth Behavioral Health. You or your representative (including a physician on your behalf) may appeal the adverse decision related to your coverage.

Step 1: Contact the Customer Service Department at the toll-free number listed on the back of your ID card to review any adverse coverage determinations/payment reductions. We may be able to resolve your issue quickly outside of the formal appeal process. If a Customer Service representative cannot change the initial coverage decision, he or she will advise you of your right to request an appeal.

Step 2: Complete and mail this form and/or appeal letter along with any supporting documentation to the address identified below. In order to process your appeal request quickly, please refer to the latest denial letter you received to ensure you are submitting your appeal to the correct address. Completing an accurate preparation of your appeal will help us perform a timely and thorough review. In most cases your appeal should be submitted within 180 days, but your particular benefit plan may allow a longer period.

You will receive an appeal decision in writing.

Requests for an appeal should include:

1. This completed form and/or an appeal letter requesting a review and indicating the reason(s) why you believe the adverse decision is incorrect and should be changed. If you submit a letter, please include all the information that is requested on this form.
2. A copy of the original claim and explanation of payment (EOP), explanation of benefit (EOB), or initial adverse decision letter, if applicable.
3. Any documentation supporting your appeal. For adverse decisions based upon lack of medical necessity, additional documentation may include a statement from your healthcare provider or facility describing the service or treatment, any applicable medical records, and/or progress notes.

Participant Name: _____ **Participant ID #:** _____

Patient Name: _____ **Date of Birth:** _____

Health Care Provider or Facility Name: _____

Date(s) of service: _____

Claim, Document or Issue ID Number: _____

Procedure/Type of Service: _____

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Appeal is being filed by:

☐ Participant/Family ☐ Health Care Provider

Name of person filling out form: _____

Signature: _____ Date: _____

Business: _____ Phone (Home): _____

Have services already been received: ☐ Yes ☐ No

Is this a second appeal? ☐ Yes ☐ No

Please check off the selection that best describes your appeal:

☐ Request for in-network coverage

☐ Coverage Exclusion or Limitation

☐ Payment Dispute (copay, deductible, Maximum Reimbursable Amount, Contracted Rate)

☐ Experimental/Investigational Procedure

☐ Medical Necessity

☐ Timely Claim Filing

Reason why you believe the adverse coverage decision was incorrect and what you feel the expected outcome should be. As a reminder, please attach any supporting documentation (for medical necessity -related denials, include medical records documentation from your health care provider or facility).

Mail the completed Appeal Request form or appeal letter along **with all supporting documentation to:**

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Important: This address is intended only for appeals. Any other requests sent to this address will be forwarded to the appropriate location, which may result in a delay in handling your request or processing your claim.

If rendering provider/facility will be sending additional clinical information, please provide with below Behavioral Appeals cover sheet.