

# Medicare Appeal Request Form

CoxHealth Medicare Advantage, CMH Medicare Advantage and  
Phelps Health Medicare Advantage



To prevent unnecessary delay in processing this appeal, please follow the steps below.

1. Complete this form and send to:

Cox HealthPlans  
Attn: Appeals and Grievance  
P.O. Box 5750  
Springfield, MO 65801

**OR**

Fax – 417-269-2949

2. Include any clinical notes or other documentation that would support the appeal. **If this information is not provided, it could significantly delay processing and affect the ultimate decision.**

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Please check one category below that most appropriately matches this appeal request.

**Standard Pre-Service Request** (the service has not yet been rendered and your patient’s condition is not considered life threatening. A determination will be made no later than 30 calendar days for medical, and seven calendar days for pharmacy, after receipt of the appeal request).

**Expedited Pre-Service Request** (the service has not yet been rendered **and** the physician confirms that this is a situation where the patient’s *life, health or ability to regain maximum function could be in serious jeopardy* if Network Health does not reach a decision within 72 hours).

**Rationale for expedited request:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Standard Post-Service Request** (the service has already been rendered. A determination will be made no later than 60 calendar days after receipt of the appeal request).

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**Please describe what you are appealing. Be specific:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Prior Authorization or Claim Number(s):** \_\_\_\_\_

(Continued on Next Page)

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Member Name:	Member ID Number:	Date of Birth:
Ordering Physician:	Facility:	
Ordering MD Phone Number:	Ordering MD Fax Number:	
Rendering MD or Facility Phone:	Rendering MD or Facility Fax:	
ICD-10 Diagnosis Code(s):		
Requested Type of Service and CPT/HCPCs code:		
Date of Service:		

**Additional Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of person completing this form:** \_\_\_\_\_

**Contact phone number:** \_\_\_\_\_ **Contact fax number:** \_\_\_\_\_

Non-Provider Representatives: You may be contacted for documentation showing your right to file an appeal on behalf of this member, such as power of attorney (POA). You may also submit an Appointment of Representative (AOR) form found at [CoxHealthMedicareAdvantage.com](http://CoxHealthMedicareAdvantage.com).