Please fax completed form to:
716-809-8335

Appeals Form (version 1.0)
www.palladianhealth.com/providers

Palladian

Section A. Provider information Appeal type ○ Standard ○ Expedited

Last name _____ Tax ID _____

Section B. Patient information Plan _____

Last name _____ Member ID _____

Section C. Denial information

Authorization number _____ Date of denial M M - D D - Y Y Y Y

Section D. Basis for appeal. (Check all that apply. Please provide any additional documentation that is needed.)

1. **Poor compliance related to…**
   - ○ patient unable to attend scheduled visits (e.g. too busy, unable to take time off work, primary caregiver at home)
   - ○ patient not performing recommended home care or home exercises (e.g. improvement only noted after visit to provider)
   - ○ difficulties communicating with patient (e.g. language, cultural, or other barriers)
2. **Recent re-injury affecting primary region of complaint…**
   - ○ continued or repeated exposure to injuring activity (e.g. unable to modify activities, unable to change nature of work)
   - ○ acute re-injury occurred on: (MM-DD-YYYY) __ __ - __ __ - __ __ __ __
3. **Potential complicating factors…**
   - ○ patient involved in litigation related to region of complaint (e.g. worker's compensation, no-fault, personal injury)
   - ○ patient receiving benefits related to ongoing incapacity (e.g. worker's compensation, SSDI)
4. **Outcomes Form does not accurately reflect patient's health status because it…**
   - ○ underestimates the severity of patient's physical or mental health (e.g. questions 1-12 on Outcomes Form)
   - ○ underestimates the severity of patient's symptoms (e.g. questions 13-16 on Outcomes Form)
   - ○ observed clinically meaningful improvements not reflected on the Outcomes Form
5. **Diagnosis recently changed for primary region of complaint based on…**
   - ○ experience treating this patient (e.g. initial working diagnosis did not accurately reflect severity of condition)
   - ○ new diagnostic testing results obtained on: (MM-DD-YYYY) __ __ - __ __ - __ __ __ __
6. **Patient not receiving required medical or surgical intervention…**
   - ○ patient unable or unwilling to undergo required medical or surgical procedure (e.g. medication, joint replacement)
   - ○ surgical or medical procedure scheduled on: (MM-DD-YYYY) __ __ - __ __ - __ __ __ __

   procedure: _____
7. **Patient has co-morbidities that interfere or delay expected improvements, including…**
   - ○ fear avoidance behavior that precludes performing supervised exercise therapy (e.g. unable to try exercises)
   - ○ severe anxiety or depression that interferes with supervised exercise therapy (e.g. unwilling to try exercises)
   - ○ poor healing response following injury or surgical procedure (e.g. excessive scar tissue formation)
   - ○ other regions of complaint in addition to primary region of complaint (please indicate below)

   _____
8. **Remaining symptoms or functional limitations expected to resolve completely with additional visits…**

   ○ Not applicable ○ 1 ○ 2 ○ 3 ○ 4 ○ other

Comments: _____

Provider signature _____ Date of appeal _____