

Section A. Provider information Appeal type Standard Expedited

Last name

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 Tax ID

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Section B. Patient information Plan

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Last name

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 Member ID

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Section C. Denial information M M D D Y Y Y Y

Authorization number

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 Date of denial

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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)

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- 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)

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- 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)

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procedure:

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- 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)

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8. **Remaining symptoms or functional limitations expected to resolve completely with additional visits...**
 Not applicable 1 2 3 4 other

Comments: _____

Provider signature

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 Date of appeal

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