Hennepin Health

Provider Use Only:

Clinical Provider Utilization Review Appeal Request

Member name _____

Member ID _____

Date of birth_____ Today's date _____

Address _____

Phone number _____

Member plan (choose one):

☐ PMAP ☐ MinnesotaCare ☐ SNBC

This form is to help you file an appeal request for Hennepin Health to review a decision we made. As a health care provider, you may appeal a **service authorization decision** without the member's consent. Examples of when to use this form include, but are not limited to:

- When there is a denial or limited authorization of the type or level of service
- Reduction, suspension, or stopping of a service that was approved before

Please explain your reasons for appealing and sign and return this form promptly. Attach additional pages as needed. You must file an appeal with Hennepin Health within 60 days after the date of the notice of denial letter. We may extend this time if you have a good reason for being late:

Signature **Date**

Appeal process for Hennepin Health

- If a claim or requested service is denied, you will receive a notice of denial letter from Hennepin Health. This letter tells you about the decision we have made about a claim or requested service.
- If you disagree with the denial, you must file an appeal with Hennepin Health within 60 days after the date of the notice of denial letter. We may extend this time if you have a good reason for being late.
- You may file an appeal online, in-writing, or by phone. If you want to file in writing, please complete this form and sign at the bottom when complete. You can mail this to us at the address listed below or deliver it in person.
- Your appeal must tell us why you disagree with our decision to deny a claim or requested service. If you need a decision quickly, you will need to state that in your appeal as well. We do offer fast appeals when medically necessary.
- There is no cost to you for filing an appeal.
- Note that your health care provider may appeal a service authorization decision without your consent.