Provider Appeal Form

Please fully complete the form and indicate the reason(s) why you believe the claim payment or determination is incorrect and should be changed. You may attach a written statement to back up your request. Please include a copy of the original claim, Explanation of Payment, and copies of any member authorizations (as applicable). All appeals must be submitted within 180 days from the original claim determination or such other applicable timeframe identified in the plan document for the underlying coverage. For avoidance of doubt, submission of this Provider Appeal Form and acceptance of such appeal by Judi Health does not waive any provision of the plan document related to assignment of benefits or otherwise.

For pre-service medical necessity appeals, please reference the phone number provided in the original determination or call 833-JUDI-HLT (833-583-4458) to reach the pre-certification department. For post-service medical necessity appeals, please initiate a retro pre-certification within 180 days of service by contacting 833-JUDI-HLT (833-583-4458).

Claim Information

Subscriber Name:	Subscriber ID Number:
Employer Name:	Group Number:
Patient Name:	Date of Birth:
Date(s) of Service:	Procedure/Type of Service:
Claim Number(s):	
Original Amount Billed:	Original Amount Paid:

Health Care Provider Information

Practitioner/Facility Name:	
Address:	City, State, Zip:
Telephone:	Fax:
Contact Name:	Title:

Type of Appeal

Please select the issue that best describes your appeal and include a brief written statement with your request.

- ☐ Timely claim filing (please include proof of timely filing)
- ☐ Benefit plan exclusion or limitation
- ☐ Maximum reimbursable amount (for out-of-network claims only)
- ☐ Contracted rate dispute (please include expected rate and/or applicable contract terms)
- ☐ Other (please indicate)

Please note that while we implement reasonable safeguards to protect your protected health information (PHI) sent through email, there is some risk your PHI could be read or otherwise accessed while in transit. If you prefer, you may instead mail or fax your information. Completed forms can be sent to:

E-mail: appeals@judihealth.com
Fax: 833-FAX-JHLT (329-5458)
Mail: Judi Health Attn: Appeals Dept 9450 SW Gemini Dr., #87234 Beaverton, OR 97008

Signature:_____ Date: _____