

This form is **only for post-service appeals**, including reconsiderations of claim denials, retrospective reviews, and denied services.

To begin the appeal review process, please use the Highmark Provider Appeal Form.

Do not use this form for **member appeals, pre-service appeals, payment disputes, or resubmissions of corrected claims.**

Your appeal request **MUST** include:

- A Provider Appeal Form with **ALL** sections completed.
- A written explanation of the appeal with clearly stated reason(s) for the appeal.
- Claim number to clearly identify the claim(s) being appealed.
- Date of service being appealed.
- Exact code(s) being appealed.
- All complete and relevant clinical documentation.
- A complete and accurate return mailing address for the appeal decision letter.

Reminder: Timely filing limits apply.

The preferred method for submitting provider appeals to Highmark is through NaviNet at connect.NaviNet.net.

Benefits and/or benefit administration may be provided by or through the following entities which are independent licensees of the Blue Cross Blue Shield Association:

Delaware: Highmark BCBSD Inc. d/b/a Highmark Health Options (Medicaid) and Highmark Blue Cross Blue Shield (D-SNP).

West Virginia: Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options (Medicaid) and Highmark Blue Cross Blue Shield (D-SNP).

Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.

Date: _____ **Line of Business:** ☐ **D-SNP** ☐ **Medicaid**

Submit your completed Provider Appeal Form using one of the following methods:

- **NaviNet** (preferred): Log in to NaviNet at connect.NaviNet.net and select Highmark Health Options Duals (D-SNP) or Highmark Health Options (Medicaid).
- **HHO WV Fax:** 1-833-957-0025 **HHO DE Fax:** 1-833-560-1828
- **Mail:** Highmark Inc., Attn: Provider Appeals, Appeals & Grievances, **HHO Duals WV**, P.O. Box 890416, Camp Hill, PA 17089-0416
- **Mail:** Highmark Inc., Attn: Provider Appeals, Appeals & Grievances, **HHO Duals DE**, P.O. Box 890416, Camp Hill, PA 17089-0416

Member Name:	Member ID Number:	Member DOB:
Provider Name:	Provider NPI:	TIN:
Provider Correspondence Address: To ensure you receive the appeal decision, please provide a complete and accurate mailing address.		
Name of Person Submitting the Appeal:	Contact Phone Number:	Fax Number:
Claim Number:	Date of Service:	Denial code(s) being appealed:
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Provider Post-Service Appeal Instructions: This form is exclusively for providers to appeal post-service denials. This includes denials due to lack of prior authorization or denials based on medical necessity. Limit one form per member.

Appeals submitted on behalf of members, or for prior authorization denials before services are rendered, are not accepted using this process. Do not submit non-participating Medicaid or D-SNP pre-service appeals using this process.

Your written appeal must contain a concise and detailed explanation of why you believe the denial was incorrect. Clearly document the specific reason for your appeal. Your appeal must also include complete and relevant supporting clinical documentation. This documentation is crucial for evaluating your appeal and must justify the medical necessity of the denied services: insufficient documentation may result in a denial. Required documentation may include, but is not limited to: physician's office notes, prescriptions, history and physical notes, admission notes, discharge summaries, operative notes, emergency room notes, lab results, radiology reports, therapy notes and any other pertinent medical records.

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