Retroactive Prior Authorization Form

Please Note: Use this form to appeal an adverse benefit determination (denied or limited authorization request) or a claim benefit denial where the member could be liable for payment. *Retroactive Prior Authorization will be considered within 30 days of the date of service. If 30 days have lapsed, please submit your claim and an appeal may be filed.*

For Retail Pharmacy appeals (a medication dispensed to a member from a retail or specialty pharmacy), please use the Retail Pharmacy Appeal Form.

For Medical Pharmacy appeals (a medication administered to a member in a facility setting (provider or infusion center) or in the home dispensed from a home infusion pharmacy). Please use this form.

For Provider Disputes of claim billing denials or contract payment amounts, please use the Provider Dispute Form.

For other complaints, please use the Customer Complaint Form.

If you need help filling out the form, call us at 1-833-412-4144.

Please include all medical documentation after this completed form when submitting to the Appeals Department.

Request Type

☐ New Appeal Submission ☐ Additional Information for Existing Appeal

Submitter

☐ Contracted Provider ☐ Member

☐ Customer Service Representative ☐ Non-Contracted Provider

☐ Authorized Representative for the Member (Please be sure you have a signed AOR/Consent Form

Member Information

Member Name_____ Member ID Number_____

Member Street Address_____

Member 2nd Street Address_____

Member City _____ State_____ Zip Code_____

Member Phone Number_____

Provider Information

Name of Provider Involved_____

Provider Mailing Address_____

Provider City _____ State_____ Zip Code_____

Phone Number_____ Fax_____ Provider NPI_____

Appeal Information

Type of Service ☐ Medical ☐ Medical Pharmacy Medication ☐ Behavioral Health

Name of Person Submitting Appeal _____

Phone Number of Person Submitting Appeal _____

Confirmation Email _____

Date(s) of Service You are Appealing _____

Appeal Type ☐ Pre-Service ☐ Post-Service

If Applicable,
Claim Number_____ Prior Authorization Number _____

Have the services been provided? ☐ Yes ☐ No

Appeal Reason (Please be Specific and Include Details)

If your appeal is about a service you get that is ending or being reduced do you want to get the service during the appeal review? You will need to file your appeal within 10 calendar days of the Notice of Action or the intended date of Healthy U planned action. You can choose to keep getting service(s) during your appeal but you might have to pay for them if we do not decide in your favor.

☐ Yes ☐ No

You have the right to submit comments, documents or information relevant to the appeal. Do you have more information you would like to send for the appeal? You can attach records below.

☐ Yes ☐ No

Submitting an Appeal

If you would prefer to fax the information to the Appeals Team, please use fax number 800-781-6260. If you would prefer to mail the information to the Appeals Team, please send to one of the following addresses:

For Expedited Processing
HealthComp UM Department
PO Box 45018
Fresno, CA 93718-5018

For Regular Processing
Mountain Health Co-Op
PO Box 30311
Salt Lake City, UT 84130

Oral requests for appeals can be made by calling 833-412-4144.

Providers may also submit their appeals online at mycarehc.com/provider.