AMERICAN COLLEGE OF PHYSICIAN ADVISORS

TO: PAYOR

Name: PAYOR Expedited Appeals & Grievances Department

Fax Number:

Date:

Reference #: Click or tap here to enter text.

FROM: Requesting Patient and Physician Information

RN/Physician: _____ **on behalf of** _____ **NPI#** _____

Address: _____

Fax #: _____ **Cell #:** _____

Patient: Click or tap here to enter text.

Address: Click or tap here to enter text.

Member #: Click or tap here to enter text.

Subject

Expedited Appeal Request for Choose an item. for _____Patient Name_____

Message

Expedited Fast Appeal: Dr. _____ feels ___Patient's Name_____ health and recovery will be adversely affected if required to wait the standard timeframe and the recommended care is further delayed.

Reason for Appeal: Dr. _____ and the patient strongly disagree with the medical director who denied this original request and feel the patient meets Medicare criteria for and will benefit from Choose an item. That cannot be accomplished at a lower level of care we formally request an expedited reconsideration of this denial by a second medical director please review the prior clinical information sent with the original authorization request and also information received via this fax.

Documents (if circled, included: Updated clinicals

Request: on behalf of the patient, please provide me a copy of all medical records, other documents and clinical guidelines used to render your decisions as offered in your denial notice.