

**APPEAL FORM**

Instructions:

In order for us to process your administrative appeal, please complete and sign this form. This form may be mailed to the Appeals Coordinator or faxed to 785-338-9020. Upon receipt of the completed form, *Beacon Health Options* will investigate your appeal and notify you of a resolution within 14 days of receiving all requested information.

By filling out and signing the attached authorization for use or disclosure of medical information form, you are also authorizing *Beacon Health Options* to obtain any medical records applicable to your appeal.

**MEMBER NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEACON HEALTH OPTIONS ID#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Treatment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider/Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Explanation of issues (please give dates, names and attach additional sheets as necessary):*

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**Provider signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Public Sector Appeals and Denials Coordinator**

**Beacon Health Options of Kansas**

**100 SE 9th Street, Suite 501**

**Topeka, KS 66612**

**Fax: (785)338-9020**