

Authorization Appeal



Complete this form to file an appeal for an authorization decision made prior-to (pre-service) or during (concurrent) services being rendered. Include supporting documentation, such as all pertinent medical records. Return by mail or fax.

Address

HealthSpring Part C Appeals
PO Box 650059
Dallas, TX 75265

Fax

Standard: 855-350-8671
Expedited: 855-350-8672

| Member information | | | |
|----------------------|----------------|-----------|-----------------------|
| First name | Middle initial | Last name | Identification number |
| Address | | City | State ZIP |
| Date of birth / / | | Phone | |

| Provider information | | | |
|------------------------------|-----|----------------|------|
| Authorization number | | Date of denial | Name |
| National Provider Identifier | | Address | City |
| State | ZIP | Phone | Fax |

Select the type of appeal

Standard (30 days) Urgent (72 hours)

By requesting an expedited appeal, I attest that waiting 30 calendar days for a standard decision on a medical item or service or seven calendar days for a standard decision on a Medicare Part B prescription drug could seriously harm the patient's life, health or ability to regain maximum function.

Explain the reasons for this appeal

Attach additional pages or information you believe may help your case, such as relevant medical records. You may want to refer to the explanation we provided in your denial.