



Appeals and Grievance Form (for Providers)

Please check as appropriate (more than one box can be checked):

- I am the member's primary care physician
- I verify that I am acting on member's behalf and with their knowledge
- I am submitting an Appeal
- I am submitting a Grievance

Provider Contact Information (Please Print):

Your Name (Facility Name): _____

Your Signature: _____ Date: _____

Street Address: _____

City, State, Zip Code: _____

Work Phone: (____) - _____ Fax: (____) - _____

NPI: _____ Tax ID: _____

Member Contact Information (Please Print):

Member Name: _____

Member's Address: _____

City, State, Zip Code: _____

Home Phone: (____) - _____ Member Number: _____

Please provide a detailed explanation of your Grievance or Appeal on the following page. If you need to provide additional information please feel free to attach that to this form.

Appeals and Grievance Coordinator

Address:

ADVANTAGE Health Solutions
Attn: Appeals and Grievance Coordinator
9045 River Road Suite 200
Indianapolis, IN 46240

Phone:

1-866-591-6737

Fax:

1-888-771-4905



ADVANTAGE
...rising above the service you expectSM

Reason for Appeal/Grievance:

Date Service or Item Received: _____ Claim Number: _____

Date of the Initial Determination Notice: _____

I do not agree with the determination. MY REASONS ARE: _____

Office Use Only

Date Received in Office _____

Appeal or Grievance Number _____