MEMBER ACENTRA HEALTH MCO EXTERNAL REVIEW FORM

IF YOU ARE SUBMITTING A REQUEST FOR AN MCO EXTERNAL REVIEW, PLEASE ENSURE ALL FIELDS BELOW ARE COMPLETED IN FULL AND SEND THE FINALIZED FORM TO DMASEXTERNALREVIEWCONTACTS@ACENTRA.COM.

ONCE YOUR REQUEST HAS BEEN RECEIVED BY ACENTRA HEALTH, A CLINICAL APPEALS SPECIALIST WILL CONTACT YOU AT THE EMAIL ADDRESS PROVIDED TO PROCEED WITH YOUR REQUEST.

MCO NAME:

MCO SERVICE AUTHORIZATION NUMBER:

MCO APPEAL ID NUMBER: MEMBER MEDICAID ID NUMBER:

MEMBER LAST NAME: MEMBER FIRST NAME:

MEMBER PHONE NUMBER: MEMBER EMAIL ADDRESS:

MEMBER MAILING ADDRESS:

PROVIDER NAME:

PROVIDER CONTACT PERSON:

PROVIDER PHONE NUMBER: PROVIDER EMAIL ADDRESS:

PROVIDER MAILING ADDRESS:

PERSON SUBMITTING THIS EXTERNAL APPEAL REQUEST:

☐ SELF ☐ PARENT ☐ LEGAL REPRESENTATIVE ☐ SERVICE PROVIDER

NAME OF PERSON SUBMITTING THIS EXTERNAL APPEAL REQUEST:

WHY ARE YOU APPEALING THE MCO DENIAL?

REQUEST TYPE: ☐ STANDARD ☐ URGENT

IF URGENT, PLEASE PROVIDE RATIONALE*:

DISCLAIMER

FAILURE TO PROVIDE APPROPRIATE AND REQUIRED CLINICAL DOCUMENTATION WILL RESULT IN THE REQUEST FOR AN EXTERNAL REVIEW BEING REJECTED FOR INSUFFICIENT INFORMATION.

*If this is an urgent request, please provide rationale for the need to expedite this request and the impact to the Member's life/limb/or safety and wellness if processed as a standard request.