CLAIM APPEAL FORM
Level Two

If you would like VOAN's Senior CommUnity Care to reconsider our initial decision on your claim, please complete this appeal form in its entirety. You must write to us within the appeal time frame noted in your contract or if no appeal guideline is noted in the contract, the appeal time will default to the CMS guidelines of 120 days from the date of our decision.

Email or fax your request directly to VOA:

- Fax your request to the Appeals Department at (970) 797-1984 or
- Email your request to claims@voa.org In subject line add "Attn: Appeals" (email must be sent secure)

SCC PACE Program/Health Plan: SCO☐ SJCKY☐ SLKY☐ SNKY☐ SMD☐ SMI☐ SNC☐

Participant name:

DOB:

Plan ID number:

Date or service: To From **Total amount billed:**

Claim number(s):

Contact info:

Your name **Provider name:**

Provider mailing address:

(Street address) (City) (State) (ZIP code)
Phone: ( ) - - Fax: ( ) - -
Your email address:

Please explain why you believe our initial decision was wrong, based on specific benefit provisions in your plan brochure (please attach additional sheet if needed):

Supporting documents may be necessary for appeal consideration; such as medical records and etc. for a review of charges.

I confirm the above information is correct.

Signature: _____ Date: _____

**Please send copies of documents that support your appeal including; physicians' letters, procedure reports, bills, medical records and explanation of benefits (EOB) forms. The review may be delayed or denied if supporting documents are not included. All requested documentation will need to be provided within 30 days from the date requested or appeal will automatically default to denial for lack of documentation. **Email appeal must be sent through secure email.