To File a Formal Second Appeal if you have Received a Denial

If you believe that this determination is not correct, you have the right to appeal the decision by filing a 2nd level appeal with Allied National. The appeals process must be initiated within 180 days of the 1st level appeal.

If your need for care is urgent, we will respond as soon as possible, but no later than 72 hours after receiving your appeal. This is an expedited appeal. In all other cases, we will give you our response no later than 30 days after you file your appeal. This is a standard appeal. There is no charge to you, the member, to file an appeal.

The following information should be included in the appeal request:

- Member's name.
- Member's contract number.
- Information to identify the claim(s) you are appealing.
- A statement explaining that you are filing an appeal and a written explanation of why you believe this case should be approved. Please submit all medical records, peer review articles, and comments for consideration that may support your appeal.

Please fill out the appeal form ATTACHED and fax it to 703-991-4496 along with any additional supporting evidence. For questions regarding a second level appeal, please contact the Allied National Customer Service at 1-800-825-7531 extension 3001.

EXOUZA
...powered by you!

PRIOR AUTHORIZATION SECOND LEVEL APPEAL REQUEST

An appeal may be filed in the event that you wish for us to reconsider and change a decision we have made about what prescription drug benefits are covered for the member. The appeals process must be initiated within 180 days of the original denial. Standard appeal requests will be reviewed within 30 working days. You may request an expedited appeal if the member's health status is jeopardized by the standard processing time in which the appeal will be processed. Expedited appeal requests will be reviewed within 72 hours. To make an appeal, please complete the form below and fax it to **703-991-4496** along with any additional supporting evidence.

SECOND APPEAL REQUEST

Please indicate the request you are submitting:

☐ **STANDARD** – decision will be made within 30 working days.
☐ **EXPEDITED** – decision will be made within 72 hours.

Date of Submission: _____

PRESCRIBER INFORMATION		PATIENT INFORMATION	
Prescriber Name	Prescriber ID	Patient Name	
Prescriber ADDRESS (street, city, state, zip)		Patient Address (street, city, state, zip)	
PHONE	FAX	Patient DOB	DIAGNOSIS

If additional space is needed, please use separate sheet and attach to form.

Prior Authorization Decision in Question:

I do not agree with the determination of the Prior Authorization request. MY REASONS ARE:

Additional information for us to consider:

I certify that the information above is accurate. I understand that penalties may apply for falsified or misrepresented information.

Requester's Signature:_____ Date:_____
Requester's Name:_____ Relationship to member:_____
Requester's Address_____ Requester's phone:_____