

CLINICAL APPEAL FORM

All fields are required. Please attach any supporting documentation related to the appeal (medical records, etc.).

LINE OF BUSINESS *(Please select one):*

- | | |
|---|---|
| <input type="checkbox"/> Regional Accountable Entity Region 4 | <input type="checkbox"/> Denver Health Medicaid Choice |
| | <input type="checkbox"/> Child Health Plan <i>Plus</i> (CHP+) |

CATEGORY OF SERVICE BEING APPEALED *(Please select one):*

- | | |
|--|---------------------------------|
| <input type="checkbox"/> Physical health | Authorization/reference number: |
| <input type="checkbox"/> Behavioral health | Dates of service appealed: |
| | Treatment/service provided: |

Provider name:	
Contact name:	
Phone:	Fax:
Member name:	Member ID:
Member date of birth:	

APPEAL TYPE *(Please select one):*

- Expedited (resolved within 72 hours, if a standard resolution would seriously jeopardize the member's life, health, or the ability to attain, maintain, or regain maximum function)
- Standard (resolved within 10 business days, excludes state holidays)

EXPLANATION OF APPEAL

A clinical appeal can be filed by mail, fax or email. To speak with someone directly, please call us at 844-683-1072.

Mail: Colorado Access Appeals
PO Box 17950
Denver, CO 80217

Fax: 844-683-1071

Email: clinicalappeals@coaccess.com