Stride℠(HMO)/(HMO-POS) Medicare Advantage
Medicare Advantage Appeal Form

Harvard Pilgrim Health Care
a Point32Health company

Instructions

Complete this form and attach documentation to support your appeal. You should also attach a copy of the explanation of benefits/payment (EOP) showing denial of the claims(s) you are appealing.

***Note*:** If you are a non-participating provider (not in the Harvard Pilgrim Stride network) you must also complete and sign the Medicare Advantage Non-participating Provider Waiver of Liability Statement. Appeal requests from out of network providers that are not accompanied by this waiver will be placed on hold until the form is received.

Fax completed form and attachments to **617-509-4225**, or mail to:
Medicare Advantage Provider Appeals, P.O. Box 690546, Quincy, MA 02269

Harvard Pilgrim reserves the right to request additional information. Incomplete forms may delay response time.

***Note*:** For **participating providers,** appeals must be received within 90 days from the date of denial on the explanation of benefits/payment (determination notice). Per the Centers for Medicare and Medicaid Services (CMS) requirements, **non-participating providers** must file an appeal for a denied claim within 65 calendar days of the denial. Appeals outside of these timeframes are considered untimely and will be denied. If you can document the existence of extraordinary circumstances that prevented timely filing of your appeal, include a detailed explanation and supporting documentation with your request.

Member Information

Name: HPHC member ID #:

Person Completing Form

Name: Phone:

Provider Information

Name: HPHC provider ID #:

NPI #: Tax ID #:

Mailing address:

Claim Information

Date on initial determination notice:

Claim number(s):

Date(s) of service: Was this claim reviewed previously? Yes No

If yes, what was the outcome?

Reason for appeal (Please provide a detailed explanation of why you believe Harvard Pilgrim Health Care should overturn the denial or partial denial of your claim. Attach additional sheets if necessary.):

Harvard Pilgrim Health Care will review your appeal request and render a written decision within 60 days from the date received. If we contact you requesting additional information and there is a significant delay in providing that information to Harvard Pilgrim Health Care, or the case requires extraordinary research to render a decision, we will inform you we need additional time.

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If you have any questions about the provider appeals process, please contact the Medicare Advantage Provider Service Center at **888-609-0692**.

Medicare Advantage Non-Participating Provider

Waiver of Liability

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Enrollee Name: Enrollee Plan ID #:

Provider Name: Dates of Service:

Provider TIN #: Claim #:

Harvard Pilgrim Health Care Stride℠(HMO/HMO-POS)

By signing below, I give up (“waive”) any right to collect payment from the enrollee (above) for the item, service or Part B drug furnished to the enrollee that the enrollee’s health plan has denied. I understand that signing this waiver doesn’t negate my right to appeal under 42 CFR §422.600.

Signature: **Date:**

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