Commercial Grievance (Appeal) Request Form

To prevent unnecessary delay in processing this grievance, please follow the steps below.

1. Fax or mail completed Appointment of Authorized Representative form (AOR) giving you authority to file this grievance on behalf of our member.
   a. Fax: (920) 720-1832 or
   b. Address: Network Health, Attn: Appeals and Grievances
      P.O. Box 120
      Menasha, WI 54952
2. Include any clinical notes or office notes that would support the grievance. **If this information is not provided, it could significantly delay processing and affect the ultimate decision** that needs to be made based on the information we have received.

Please check the grievance category below that most appropriately matches your patient's situation.

☐ **Standard Pre-Service Request** (the service has not yet been rendered **and** your patient's condition is not considered life threatening).

☐ **Expedited Pre-Service Request** (the service has not yet been rendered **and** the physician confirms that this is a life-threatening situation where the patient's life, health or ability to regain maximum function could be in serious jeopardy if Network Health does not decide the grievance quickly. If this is a life-threatening situation, Network Health will decide the grievance within 72 hours of receipt).

Describe Rationale for Expedited Request: _____

☐ **Standard Post-Service Request** (the service has already been rendered).

Please describe what you are appealing. Be specific: _____

Name and Title of Person Filling Out Form: _____

MD Signature (authorization of grievance on behalf of member):_____

Contact Phone Number: **Contact Fax Number**:

Member Name:	Member ID Number:	Date of Birth:
Name of Provider Appealing:		
Provider Type (DME supplier, facility, treating MD, etc.):		
Provider's Phone Number:	Provider's Fax Number:	
Signed Appointment of Representative (AOR) form: ☐ **Yes** ☐ **No** (please send signed form with this request)		

Comments:

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