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):*

☐ CHP+ offered by Colorado Access

☐ CHP+ State Managed Care Network

☐ Regional Accountable Entity Region 3

☐ Regional Accountable Entity Region 5

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

☐ Physical Health

☐ Behavioral Health

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 17189
Denver, CO 80217

Fax: 844-683-1071

Email: clinicalappeals@coaccess.com