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):*

☐ Regional Accountable Entity Region 4

☐ Child Health Plan *Plus* (CHP+)

☐ Denver Health Medicaid Choice

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

☐ Physical health

☐ Behavioral health

Authorization/reference number:

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 17189
Denver, CO 80217

Fax: 844-683-1071

Email: clinicalappeals@coaccess.com