SUMMIT POINTE PROVIDER APPEALS – EXTERNAL CLAIMS

Provider Information

Provider Name: ____

Program/Home Name: ___________________________ **Contact Name:** _________________________________

Contact Email: _________________________________ **Contact #:** _____________________________________

Please indicate the level of appeal you are filing: ☐ **Level 1** ☐ **Level 2** ☐ **Level 3 – SWMBH**

Claim information

Customer ID # _________________________ **Claim #:** ________________________

Billing Code [CPT + Modifier]: ____

DOS: ____
(If time-based code, include start/stop time for each DOS; attach separate sheet if necessary)

Total Amount ($) of Appeal Requested: _________________________

Reason for Appeal:

____ _______________________

External Provider Signature **Date**

SUMMIT POINTE ADMINISTRATIVE REVIEW

Date Appeal Was Received: ____________________________ **Date of Review:** ___________________________

Decision: ☐ **Full Payment Approved** ☐ **Partial Payment Approved** ☐ **Appeal Denied**

Amount approved for Reimbursement: ________________________ **Pay from:** ☐ **GF** ☐ **Insurance**

Determination Notations:

Treatment Plan Dates:

Authorization Dates:

Reviewed by: ____
Director

Approved by: ____ **Date:** __________________________
CEO

Send all appeals to:

Summit Pointe
Provider Appeals
140 West Michigan Avenue, Battle Creek, MI 49017
Email: providerclaims@summitpointe.org
Fax #: 269-966-2844

Failure to adequately complete this form or provide necessary documentation will result in automatic denial

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