HEALTHKEYS APPEAL FORM

INSTRUCTIONS

PLEASE SELECT BELOW THE TYPE OF APPEAL OR ALTERNATIVE YOU WOULD LIKE TO FILE:

_______A Disputed Result (Front Page only)   ________A Reasonable Alternative Standard (Both sides)

This form and ALL supporting documentation must be received within forty-five (45) days from the date on the results report received by the participant. Please make sure that all appropriate sections below are completed in full. The appeal will be evaluated and it may include consultation with a medical advisor and/or physician, as necessary. By your signature you are authorizing the release of the medical information that HealthKeys might need to process this appeal. The decision rendered will apply to the applicable plan year. You may be responsible for the cost of the appeal. Check with your HR Department. Submit invoices that you may receive with this form for reimbursement of specific costs associated with the appeal. Direct any questions you may have to The Appeals Department at 1-800-732-1299.

PARTICIPANT INFORMATION

FIRST NAME:			LAST NAME:	
STREET ADDRESS, PO BOX			APT#	CITY
STATE	ZIP CODE	HOME PHONE (WITH AREA CODE)		
DAYTIME OR CELL PHONE (WITH AREA CODE)			EMAIL ADDRESS	
EMPLOYER NAME			Employee Identification #	Date of Birth
PARTICIPANT SIGNATURE	DATE	SIGNATURE AGGREMENT: By signing, I verify that the information supplied by myself or any representative here is true and complete. I also understand that any person who knowingly and with intent to injure, defraud, deceive any health care vendor, files a statement of claim, or any application containing any false, incomplete or misleading information will be subject to criminal penalties applicable to state laws.		

DISPUTED RESULT

Circle below which standard was used

APPEAL CATEGORY (CHECK ALL THAT APPLY)	NATIONAL INSTITUTES OF HEALTH TARGET	RELAXED STANDARD	ORIGINAL RESULT	RE-TESTING OPTIONS (At the Appeals Department discretion)	APPEALED RESULT
BLOOD PRESSURE ☐	**≤ 120/80**	**≤ 130/85**		**1) Re-test by original screening company 2) Re-tested by your physician 3) Provide a reading that is within 60 days of the report date.**	
LDL CHOLESTEROL ☐	**≤ 100**	**≤ 130**		**1) Re-test by original screening company 2) Use approved voucher with certified lab 3) Provide a reading that is within 60 days of the report date.**	
GLUCOSE ☐	**≤ 100**	**≤110**		**1) Re-test by original screening company 2) Re-tested by your physician 3) Provide a reading that is within 60 days of the report date.**	
TOBACCO USE ☐	**Negative**	**Negative**		**1) Re-test by a certified lab using an approved voucher 2) Provide a reading that is within 60 days of the report date.**	
BODY MASS INDEX ☐	**< 25**	**≤ 29**		**1) Re-test by original screening company 2) Re-tested by your physician**	

HEALTHCARE PROVIDER: (M.D., D.O., P.A.,N.P.) A FULL SIGNATURE IS REQUIRED WITH PRINTED NAME, DATE, TAX ID AND PHONE NUMBER

PROVIDER SIGNATURE	DATE	TAX ID
PROVIDER PRINTED NAME	PHONE NUMBER	

HEALTHKEYS APPEAL FORM

REASONABLE ALTERNATIVE STANDARD

What is a Medical Exception? If it is unreasonably difficult due to a medical condition for an individual to achieve the standards under the program or if it is medically inadvisable for an individual to attempt to achieve the standards under this program.
The standards under this program are either the National Institute of Health or a relaxed standard.

An alternative might be a reduction from the current results.
i.e. 5% improvement over the prior test cycle.

	National Institute of Health Standard (NIH)	Relaxed Standard	Patients Biometric Screenings Scores	5% Improvement
Systolic Blood Pressure	**≤ 120**	**≤ 130**		
Diastolic Blood Pressure	**≤ 80**	**≤ 85**		
LDL Cholesterol	**≤ 100**	**≤ 130**		
Blood Glucose	**≤ 100**	**≤110**		
Body Mass Index	**< 25**	**≤ 29**		

PROVIDER STATEMENT

I have reviewed this participant's biometric screening results and agree that attempting to achieve the goals, will be medically inadvisable.
I also believe that the reasonable alternative standard which is an improvement of 5 % on the biometric screening scores, could also be harmful to this patient.

REQUIRED:

What alternative goals do you believe would be reasonable and advisable by the next testing cycle. (amount of weight loss, BMI cholesterol reduction goals, etc.)? If alternative goals cannot be met by the next testing cycle (e.g. due to pregnancy), please explain.

HEALTHCARE PROVIDER- APPEAL CANNOT BE PROCESSED WITHOUT A FULL SIGNATURE WITH PRINTED NAME, DATE, TAX ID AND PHONE NUMBER

PROVIDER SIGNATURE	DATE	TAX ID
PROVIDER PRINTED NAME	PHONE NUMBER	

The completed form and supporting documentation should be mailed/faxed to:

Appeals Department at WellChoice Inc.
5250 Old Orchard Road, Suite 300 PMB #3022
Skokie, Illinois 60077

Phone: 1-800-732-1299
Fax: 1-847-763-1791