# Provider Appeal Form

SAN FRANCISCO HEALTH PLAN
Here for you

**Instructions:**

- **Complete form.** All fields marked with an asterisk (*) are required.
- Required attachments:
  - o NOA denial letter
  - o Any supporting clinical documentation
- **Once the form has been filled out,** the provider may submit their appeal to SFHP's UM Department via fax, secure email, or U.S. mail.

Phone: **1(415) 547-7818 ext. 7080**
Fax: **1(415) 547-7829**

Email: **providerappeals@sfhp.org**

Mailing Address:
**SFHP Utilization Management**
**P.O. Box 194247**
**San Francisco, CA 94119-4247**

## Provider Details:

Provider Name*: NPI #:

Medical Group:

Select type: ☐ Primary Care ☐ Vendor/Ancillary ☐ Specialist ☐ Hospital:

Address:

City: State: CA Zip Code:

Telephone*: ext: Fax*:

Email:

## Authorization Details:

Hospital Status: ☐ Inpatient ☐ Outpatient (DME, Home Health, etc.)

Member Name*: SFHP ID #: Date of Birth*:

Authorization Reference #*: Requested Service*:

Have these services been rendered?*: ☐ Yes ☐ No

Place of Service*: Date of Service:

## Appeal Information:

Provide a clear explanation of why the denial decision should be overturned.
Please attach a separate sheet if more space is needed.

Make sure the following are attached: NOA Denial Letter and supporting clinical documentation

## Contact Information (if different than the provider):

Name: **Today's Date*:**

Title:

Telephone: ext: Fax:

For more information on provider appeals, please contact SFHP's UM Department at **1(415) 547-7818 ext. 7080**, open Monday through Friday from 8:30am to 5:00pm, or visit our website at www.sfhp.org/providers.