Provider Appeal Submission Form

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

A provider appeal may be registered by completing this form and mailing it with any supporting documentation to the address below:

First Choice Next
Provider Appeals
P.O. BOX 7201
London, KY 40742-7201

Submission date:

Section I: Provider/facility information	
Health care provider/facility name:	
Requesting provider signature:	
Submitter name (if different from above):	
Phone:	Fax:
Tax ID:	NPI:
Provider mailing address:	
Referring health care professional name (if applicable):	

Section II: Member information (if applicable)
Member name:
Member date of birth:
Member ID (copy from member ID card):

Section III: Claim information (if applicable)							
Claim identification number:							
Date of notification/payment from plan:							
Dates of service To:				From:			
CPT codes							
Diagnosis codes							

A provider has the right to appeal adverse actions taken by First Choice Next. Appeals are available to a provider, including for the following reasons. **Please indicate the type of appeal.**

- ☐ **Program integrity-related findings or activities**
  - ☐ Finding of fraud, waste, or abuse by the plan
  - ☐ Finding of or recovery of an overpayment by the plan
  - ☐ Withholding or suspension of a payment related to fraud, waste, or abuse concerns
- ☐ **Denial of a claim**
  - ☐ Provide denial reason

☐ **Credentialing-related reasons**

- ☐ A determination not to renew or an existing contract based solely on objective quality reasons outlined in First Choice Next's Objective Quality Standards
- ☐ A determination not to initially credential and contract with a provider based on objective quality reasons

☐ **Agreement-related reasons**

- ☐ Violation of the agreement between the individual and family health plans offered on and off the Exchange and the provider.
- ☐ Termination of a provider agreement before the agreement period has ended for reasons other than when First Choice Next's Fraud Control Unit, Centers for Medicare & Medicaid Services (CMS), South Carolina Department of Insurance, or a government agency has required the plan to terminate the agreement.

☐ **Other reason**

☐ Supporting documentation attached

State your rationale for the appeal and the expected outcome. **(Please attach any supporting documentation.)**

If you have any questions, please call your Account Executive or Provider Services at **1-833-986-7277.**