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 #:** _____ **Batch #**_____

Billing Code [CPT + Modifier]: _____

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

Total Units Requested per billing code: _____

Total Amount ($) Requested: _____

Reason for Appeal:

_____ _____

External Provider Signature **Date**

Send all appeals to:

Summit Pointe - Provider Claims
Email: providerclaims@summitpointe.org

Attached any additional documentation if applicable.

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

SUMMIT POINTE ADMINISTRATIVE ONLY

Review

Date Appeal Was Received: _____ Date of Review: _____

Review Notations:
Case Manager:

Treatment Plan Dates:

Authorization Dates:

Determination

Decision: ☐ **Full Payment Approved** ☐ **Partial Payment Approved** ☐ **Appeal Denied**
Amount approved for Reimbursement: _____ Pay from: ☐ **GF** ☐ **Insurance**

Determination Notations:

Reviewed by: _____ Date: _____
Director

Determination Processing /Notification

Determination Processing Notations

Approved by: _____ Date: _____
CEO