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

Version 5/28/2024

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