

Priority Partners, Johns Hopkins US Family Health Plan (USFHP), Employer Health Programs (EHP) — Participating Provider Appeal Submission Form

Clinical/Medical Necessity Appeals Only

This form is to be used to appeal a medical necessity or administrative denial. Please submit one form for each appeal. Incomplete appeal forms will be returned unprocessed. Send this form with a letter stating your reason for appeal and all pertinent medical documentation to support the appeal request for Priority Partners, USFHP & EHP to Johns Hopkins Health Plans, Appeals Department, Fax 410-762-5304 or 7231 Parkway Drive, Suite 100, Hanover, MD 21076. For more detailed information on appeal policies and procedures, please reference the Provider Manual for the applicable line of business and/or your Provider Participation Agreement.

Date of Submission:	
Please Check Box for Health Plan	
☐ Priority Partners 1st Level ☐ Priority Partners 2nd Level	☐ EHP (Ist Level Only) ☐ USFHP (Ist Level Only)
Provider/Appellant Information	
First Name/Facility Name:	Last Name:
NPI #:	Tax ID #:
Address:	City/State/Zip Code:
Telephone:	Fax:
Contact Person:	
Member (Patient) Information	
First Name:	Last Name:
ID #:	Date of Birth:
Service Provided	
Date(s) of Service:	Place of Service:
Claim #:	Authorization #:
Reason for Appeal	
□ ER □	☐ Code Review/Claim Check
	☐ Itemized Bill with Medical Records
	☐ Other/Attach Additional Information or Explanation
·	☐ Clinical Review for Medical Necessity
☐ Administrative Denial (Must include documentation of extenuating circumstances to be reviewed)	

PRFORM2-EHPPUSFHP-REVI2-13-23

Notes: