GRIEVANCE LEVEL II – BHA
SUBMISSION FORM

Provider Information

Referring Contact: _____ Email: _____

Provider Name: _____ Provider NPI: _____

Telephone: _____ Provider MA: _____

Mailing Address: _____

Patient Claim Information

Patient Name: _____ Patient DOB: _____

Patient MA#: _____ Patient MCO: _____

Patient SS# (if no MA#): _____ Date(s) of Service: _____

Type of Service: _____ Primary Discharge Diagnosis: _____

Beacon Health Options Information

Date Bill Submitted to BHO: _____ Remittance Date: _____

Reason for Appeal: _____

_____

Reason for Denial: _____

_____

Report Date of Appeal/Decision: _____

**** Attach All Required Documentation**

Managed Care Organization Information (If Applicable)

Date Bill Submitted to MCO: _____ Remittance Advice Date: _____

Reason for Appeal: _____

_____

Reason for Denial: _____

_____

Report Date of Appeal/Decision: _____

**** Attach All Required Documentation**

The information required for a complete submission has PHI, therefore, submission should be faxed, mailed or sent via a password protected secure email