Request for Appeal Form

1. **Standard Appeal:** The appellant submits the Request for Appeal form within 180 days of the denial date. Acentra will conduct a full and fair review of your claim and provide you with a written determination. Additional documentation will be considered. Acentra renders a decision in writing within 30 days of receiving the Request for Appeal.
2. **Expedited Appeal:** The appellant submits the Request for Appeal form within 180 days of the denial date. Acentra will conduct a full and fair review of your claim and provide you with a written determination. Additional documentation will be considered. Acentra renders a decision in writing within 3 business days of receiving the Request for Appeal.

2. Please mail or fax this completed form and all other documentation supporting the appeal request to: Acentra 6802 Paragon Place, Suite 440, Richmond, VA 23230| Fax 512-975-7642.

Type of Appeal Requested: ☐ Standard Appeal ☐ Expedited Appeal

Confirm required attachment: ☐ Denial letter

Participant Name: _____

Participant Address: _____

Phone Number: _____Cell Number: _____

Acentra Reference Number: _____

Participant ID# (from insurance card): _____

Treating Health Care Provider Name: _____ ☐ Check if Expedited

Provider Mailing Address: _____

Provider Contact Person: _____Phone Number: _____

Licensure or Area of Clinical Specialty: _____

Physician Certification for Expedited Appeal: I certify that waiting the full 30-day determination period would jeopardize the life or health of the participant or the participant's ability to regain maximum function.

Signature of Physician (ONLY if Expedited): X_____ Date: _____

Summary of Appeal Request (use additional pages if needed):