

APPEAL FORM



IMPORTANT INFORMATION ABOUT YOUR APPEAL

- You and your health care provider must complete and sign the attached form. Failure to complete the form, including **appropriate signatures**, will prevent timely processing of your appeal.
- N Good Health must receive the completed appeal form and all supporting documentation by **Dec. 1**, the program deadline.
- N Good Health will evaluate your appeal form, including consultation with your health care provider if necessary. N Good Health will let you know the final decision about your appeal within 14 days of receiving your form and documentation. The decision will apply only to the incentive period under review.
- You will be responsible for the cost of any retesting and/or medical documentation supplied. The retesting cost may be covered by your current health plan if a wellness benefit is available and has not been exhausted. Verify your coverage with your plan administrator. If you have a Norton Healthcare medical plan, call Anthem Member Services at **(844) 344-7416**.

The appeal form is color-coded. Fill out the blue sections. Ask your health care provider to fill out the green sections.



PARTICIPANT



HEALTH CARE PROVIDER



STEP 1 - Fill out this section completely.

STEP 2 - Identify the type of appeal you are filing:

TYPE 1 – DISPUTED ACCURACY: Your wellness exam results were not reported or reported incorrectly.

TYPE 2 – IMPROVEMENT: Your wellness exam results have improved by 10% since you had your wellness exam.

STEP 3 - Sign the form to authorize the processing of your appeal.

Important: Ask your provider's office for a copy of the completed and signed form to keep for your records. It is your responsibility to ensure that N Good Health receives the form.

STEP 4 - Identify which wellness exam test results you are appealing. Check the box(es) for the appropriate criteria and fill in your results from your N Good Health wellness exam.

Important: If you are submitting a Type 2 (improvement) appeal, your retested lab results must be dated after your original wellness exam date and before **Dec. 1**. You must include all lab results when you submit your appeal form.



STEP 5 - Write in or attach all lab result values.

Important: Biometric values and lab work must be authorized by a provider and may be performed by an approved health professional (M.D., D.O., DNP, APRN, P.A., P.A.-C.). A registered nurse (R.N.) may record the patient's height, weight, waist circumference and blood pressure. Retested lab work must be done by a CLIA-certified laboratory.

STEP 6 - Sign the form to authenticate that the results are complete and accurate. Scan and email the completed form to the Norton Healthcare N Good Health Department at ngoodhealth@nortonhealthcare.org.

The image shows a sample of the N Good Health Appeal Form with numbered callouts 1 through 6 indicating key sections. The form includes fields for participant information, reason for appeal, signature, criteria for appeal, biometric and lab results, and provider signature. It also contains instructions and contact information for the Norton Healthcare N Good Health Department.



PARTICIPANT



HEALTH CARE PROVIDER



PLEASE PRINT ALL INFORMATION CLEARLY. FAILURE TO COMPLETE THIS FORM ACCURATELY MAY RESULT IN A DENIAL OF YOUR APPEAL.

1 PARTICIPANT INFORMATION

First name:

Last name:

Date of birth: / /

AHSN or spouse member #:

Phone: - -

2 REASON FOR THE APPEAL [Choose type(s) that best describes your request.]

- TYPE 1 – DISPUTED ACCURACY:** My results were not reported or reported incorrectly. **TYPE 2 – IMPROVEMENT:** My results have improved by 10% since my wellness exam.

3 PARTICIPANT SIGNATURE AND CONSENT



By signing this form, I verify that the information supplied here by me or my representative is true and complete. I acknowledge that providing false information to receive program incentives could result in disciplinary action, as well as the immediate, permanent withdrawal of the program incentives. I acknowledge that the information provided may be subject to verification. Further, I authorize the release of any medical information that N Good Health might need in order to process this appeal.

Participant signature: _____ Date: / /

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CRITERIA BEING APPEALED			RECORD NEW BIOMETRIC VALUES (OR ATTACH LAB RESULTS) FOR ALL THAT APPLY	
<input checked="" type="checkbox"/>	Outcome (Check all that apply)	ORIGINAL RESULT TO APPEAL	NEW RESULT	DATE of RESULT
<input type="checkbox"/>	BMI (body mass index)			
<input type="checkbox"/>	WAIST CIRCUMFERENCE			
<input type="checkbox"/>	BLOOD PRESSURE			
<input type="checkbox"/>	CHOLESTEROL LDL			
<input type="checkbox"/>	GLUCOSE/A1C			
<input type="checkbox"/>	TOBACCO USE			

RECORD RESULTS OR ATTACH LAB DOCUMENTATION

6 HEALTH CARE PROVIDER'S SIGNATURE — MUST BE M.D., D.O., DNP, APRN, P.A. OR PA-C



Provider printed name: _____

Provider signature: _____ Date: / /

National provider identifier:

Phone number: _____

If a Norton Healthcare Employee Health Office, please check your location:

- Norton Audubon Hospital Norton Brownsboro Hospital Norton Healthcare Pavilion Norton Women's & Children's Hospital

Note: No NPI is needed for Employee Health Offices

- Norton Clark Hospital Norton Scott Hospital Norton King's Daughters' Hospital

BEFORE SUBMITTING YOUR APPEAL

- Did you check off all the criteria you are appealing?
 Did you and your health care provider sign the appropriate sections?
 Did your health care provider provide documentation/statements as appropriate for your clinical circumstances?

Fax completed form to (502) 666-7667
 Or scan completed form to the
 Norton Healthcare N Good Health Department.
 Email: ngoodhealth@nortonhealthcare.org