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.

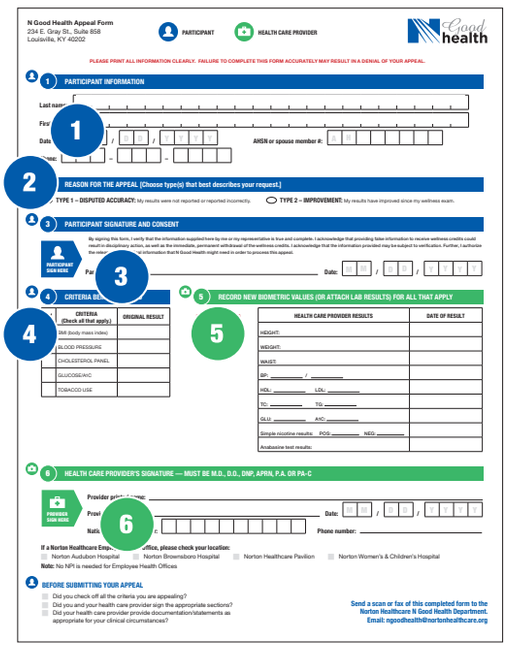
TYPE 2—IMPROVEMENT: Your wellness exam results are now within normal/low risk range or have improved by **10%** since you had your wellness exam.

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.


N Good Health Appeal Form
234 E. Gray St., Suite 858
Louisville, KY 40202

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

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 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 wellness credits could result in disciplinary action, as well as the immediate, permanent withdrawal of the wellness credits. I acknowledge that the information provided may be subject to verification. Further, I authorize the release of information that N Good Health might need in order to process this appeal.

PARTICIPANT SIGN HERE

4 CRITERIA

CRITERIA (Check all that apply)	ORIGINAL RESULT
BMI (Body Mass Index)	
BLOOD PRESSURE	
CHOLESTEROL PANEL	
GLUCOSE/A1C	
TOBACCO USE	

5 RECORD NEW BIOMETRIC VALUES (OR ATTACH LAB RESULTS) FOR ALL THAT APPLY

HEALTH CARE PROVIDER RESULTS	DATE OF RESULT
HEIGHT:	
WEIGHT:	
WAIST:	
BP: /	
HDL: LDL:	
TC: TG:	
GLU: A1C:	
Simple nicotine results: POS: NEG:	
Anabasine test results:	

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

PROVIDER SIGN HERE

Provider

Date:

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

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?

Send a scan or fax of this completed form to the Norton Healthcare N Good Health Department.
Email: ngoodhealth@nortonhealthcare.org

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**.

N Good Health
234 E. Gray St., Suite 858
Louisville, KY 40202

N Good Health Appeal Form
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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

Last name:

First name:

Date of birth: M M / D D / Y Y Y Y

AHSN or spouse member #: A H

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 are now within normal/ low risk range or have improved by **10%** since my wellness exam.

3 PARTICIPANT SIGNATURE AND CONSENT

PARTICIPANT SIGN HERE

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: M M / D D / Y Y Y Y

4 CRITERIA BEING APPEALED

✔	CRITERIA (Check all that apply.)	ORIGINAL RESULT
	BMI (body mass index)	
	BLOOD PRESSURE	
	CHOLESTEROL PANEL	
	GLUCOSE/A1C	
	TOBACCO USE	

5 RECORD NEW BIOMETRIC VALUES (OR ATTACH LAB RESULTS) FOR ALL THAT APPLY

RECORD RESULTS OR ATTACH LAB DOCUMENTATION.

HEALTH CARE PROVIDER RESULTS	DATE OF RESULT
HEIGHT:	
WEIGHT:	
WAIST:	
BP: _____ / _____	
HDL: _____ LDL: _____	
TC: _____ TG: _____	
GLU: _____ A1C: _____	
Simple nicotine results: POS: _____ NEG: _____	
Anabasine test results:	

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

PROVIDER SIGN HERE

Provider printed name: _____

Provider signature: _____ Date: M M / D D / Y Y Y Y

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

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?

Send a scan of this completed form to the Norton Healthcare N Good Health Department.
Email: ngoodhealth@nortonhealthcare.org