**Request for Appeal Form**

1. **Standard Appeal:** The appellant submits the Request for Appeal form within 180 days of the denial date. Kepro will conduct a full and fair review of your claim and provide you with a written determination. Additional documentation will be considered. Kepro 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. Kepro will conduct a full and fair review of your claim and provide you with a written determination. Additional documentation will be considered. Kepro 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: Kepro 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kepro 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):**