UM APPEAL COVER SHEET

Health Plan of San Joaquin

INSTRUCTIONS

- Please complete the below form for UM Appeals. Fields with an asterisk (*) are required.
- Provide clinical documentation to support the Appeal.
- Return the completed form via mail, fax or in person to:

Health Plan of San Joaquin
"Attn: Grievance Coordinator"
7751 S. Manthey Road
French Camp, CA 95231

OR

In person to: Health Plan of San Joaquin
"Attn: Grievance Coordinator
1025 J Street
Modesto, CA 95354

- Fax: (209) 461-2550

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

* Patient Name:	Date of Birth:	
* Health Plan ID Number:	Patient Account Number:	Request/Authorization # ('R' number)
Service "From/To" Date: (*If Post Service Request)		

APPEAL DETAIL ☐ Documentation Included

☐ Appeal of Medical Necessity / Utilization Management Decision

☐ Disputing Level of Care

Description of Appeal (Be specific):

*Contact Name (please print)	Title	( ) *Phone Number
Signature	Date	( ) Fax Number