St Luke's™
Health Plan

PROVIDER APPEAL AND CLAIMS INQUIRY FORM

If you disagree with a denial or reduction of benefits by St. Luke's Health Plan, or the way a claim was processed, use this form to request an appeal or dispute a payment decision.

REASON FOR DENIAL OR REDUCTION:

- ☐ Not medically necessary
- ☐ Service deemed experimental or investigational (E&I)
- ☐ No preauthorization obtained
- ☐ Application of coding edits
- ☐ Other coding issue (*please specify*): _____

IMPORTANT: Denials based on benefit limits and benefit exclusions, as well as denials of Higher Level of Benefits waivers, must be appealed *by the member*. These denials cannot be appealed by a provider, unless the provider has been formally appointed by the member as an authorized representative for the member's appeal.

PROVIDER CONTACT INFORMATION:

Date:	Provider Name:		
Office Contact:	Contact Phone Number:		
Office Address:	City:	State:	Zip:

CLAIM INFORMATION:

Subscriber ID:	Patient Name:
Dates of Service: _____ _____	
Claim #:	Authorization #:
Denial reason code(s):	

Notes attached? ☐ Yes ☐ No

***All** appeals require the submission of notes or other supporting documentation.*

Send completed forms via email or mail:

Fax: (888) 206-3092

Email: customercare@stlukeshealthplan.org

Mail: ATTN Customer Care St. Luke's Health Plan, PO Box 91010 Seattle, WA 98111

Questions? Call Customer Care at (833) 478-5853