Parkland
Community Health Plan

Provider Level I & Level II Claim Appeal Request

PCHP offers Level I and Level II claim appeal request opportunities through our Claim Appeal Process. A Level I appeal is your initial request to dispute the outcome of a finalized claim. If you are dissatisfied with the outcome of a Level I appeal, you have the option of submitting a Level II appeal with additional supporting documentation. Level I appeals must be received by PCHP within 120 days from the date of the last denial of and/or adjustment to the original claim. Level II appeals must be received by PCHP within 30 calendar days from the date on the level I claim appeal upheld letter.

PCHP providers must exhaust the complaints or Appeals process with PCHP before filing a complaint with HHSC. If after completing this process, the provider believes they did not receive full due process from the managed care medical they may file a complaint or inquiry by one of the below methods:

Emailing HPM Complaints

Using the Online Question or Complaint Form

Mailing the complaint inquiry to:
Texas Health and Human Services Commission
Medicaid/CHIP
Health Plan Management
Mail Code H-320
P.O. Box 85200
4900 N. Lamar
Austin, TX 78708

Submitting a Level I or Level II Claim Appeal Request

Providers have the option of submitting claim appeal requests online through the PCHP Provider Portal or by postal mail. Claim appeal requests submitted by fax or email will not be accepted by PCHP.

PCHP strongly recommends providers utilize the PCHP Provider Portal to submit claim appeal requests. The Provider Portal offers several benefits including the ability to:

- Receive immediate confirmation of receipt and a tracking number for your request;
- Utilize self-service options to check claim appeal status; and
- Easily upload supplemental or missing supporting documentation, if needed.

Online – Provider Portal

The Appeals and Complaints section of the PCHP Provider Portal allows providers to submit an Adverse Determination Appeal (on behalf of a PCHP member), a Level I or II claims appeal, or a complaint. Access your existing portal or create your account at https://providers.parklandhealthplan.com/login/.

Postal Mail

The below claim appeal form must be submitted for each claim number being appealed. PCHP is unable to accept a claim appeal request form with more than one claim number on the form.

New, corrected or rejected claims will not be accepted through a claim appeal request. These must be submitted using the standard claim submission processes outlined in the PCHP Provider Manual.

Once the requested information has been completed on the Claim Appeal Form, please mail with supporting documentation to the address below:

Parkland Community Health Plan
P.O. Box 560347
Dallas, TX 75356-9005

Questions regarding a submission should be directed to the Provider Services call center according to the type of coverage:

Member Coverage Type	Contact Number
STAR	1-888-672-2277
CHIP/CHIP-Perinate	1-888-814-2352

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This form should be used for provider claim appeals only. Pre-service appeals for Medical Necessity should be made utilizing the information provided with your adverse benefit determination Notice of Action or by calling the PCHP Provider Services Call Center number as indicated below.

Claim Appeal Type

☐ Level I ☐ Level II – Please include the case number of the Level I Appeal: ____________________________

Requesting Provider Information

Date: ___________________________________ Date(s) of Service: _________________________

Provider NPI: ________________________ Provider/Facility Name: ____

Claim Number: _______________________________________ Billed Amount: _________________________________

Office Contact: _______________________________________

Office Phone Number: _________________________________ Office Email: ____

Office Mailing Address: ____

PCHP Member Information

Member ID: ________________________ Claim Number: ______________________ Date(s) of Service: ___________________

Member Last Name: _________________ Member First Name: _________________ Billed Amount: ______________________

In the space below, please describe in detail the reason for your appeal request. Please note that illegible responses and/or documentation may result in processing delays.

Submit this form and supporting documentation via postal mail or complete online utilizing PCHP's provider portal and upload all supporting documentation according to the instructions on Page 1.

Please contact the PCHP Provider Services Call Center for questions regarding a submission of an appeal:

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STAR	1-888-672-2277
CHIP/CHIP-Perinate	1-888-814-2352