BEHAVIORAL APPEALS COVER SHEET

EVERNORTH

This form may be completed, attached to the appeal request form and submitted along with clinical information to support your appeal request. To help Evernorth better understand your request, please complete all sections as specifically and clearly as possible. Typed responses are preferred. Omissions, generalities, and illegible text may result in the return or your request form for completion or clarification.

If you need assistance or have questions regarding this form, please contact our appeals team at **800.241.4057**, ext. **7962009**.

Important: *Please enter all dates in mm/dd/yyyy format.*

Appeal Request Information		
Today's Date: ______	☐ Pre-service/concurrent appeal request	☐ Post-service appeal request

Policyholder/Customer Information

(Check One) ☐ Mr. ☐ Mrs. ☐ Ms.

Customer Name (First): ______ (Last): ______ Birthdate: ______

Evernorth ID Number: ______

Social Security Number *(Optional):* ______

Provider/Facility Information

Provider/Facility Name: ______

Taxpayer Identification Number: ______

Service Address: ______ City ______ State ______ Zip ______

Supervising Provider/Utilization Reviewer's Name (First): ______ (Last): ______

Work Phone: ______ Ext.: ______

Issue ID *(found on denial letter)*: ______

Dates of service requested: ______

Important: We recommend that you complete this form, save it to your computer and submit it following the instructions in the denial letter with all relevant clinical information.

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