American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

APPEAL / GRIEVANCE SUBMISSION

For questions, please call ASH at 800.972.4226

Please complete this form in its entirety and submit to ASH Appeals and Grievances Department at the address listed above. You may also submit an appeal or grievance online through ASHLink at www.ashlink.com or ASHCompanies at www.ashcompanies.com.

ASH Contracted Provider Submitting Appeal / Grievance

Name_____

Address_____

City_____ State_____ Zip_____

Member Information

Member Name_____

Member ID_____

Member Birthdate_____

Member Health Plan_____

Reason for Appeal / Grievance

Please indicate which type you are submitting (check only one):

☐ Clinical Appeal (i.e. office visit non-approval, date range reduction)

or

☐ Administrative Appeal (i.e. submission timeframe non-approval, patient eligibility non-approval)

or

☐ Grievance (i.e. formal complaint regarding ASH policies, procedures or service unrelated to an adverse determination/non-approval)

Treatment Form # **or** Claim # (if applicable)_____

Dates of Service_____ to_____

Appeals can be submitted if you are dissatisfied with an ASH determination. If you have not received an ASH determination, you should submit your claim or treatment form. If you are dissatisfied once you receive an ASH determination, you may submit an appeal at that time.

Please explain in detail the rationale for your appeal or grievance. Attach additional documentation as necessary.

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Please submit all documentation that will substantiate your appeal or grievance.