Clinical Appeals Provider Form

Clinical appeals must relate to an authorization denial for medical necessity or experimental/investigational procedures. *If you are disputing a claim determination made by Oscar, use the* ***Claims Disputes*** *Provider Form. If you are submitting a claims-related document (e.g., medical record, itemized bill) that is not a dispute or appeal, use the* ***Claims-Related Documents*** *Provider Form.*

Provider information		
First name	Last name	
Provider NPI	Group NPI	Provider TIN
Facility / Group Name	Are you contracted with Oscar? ◯ Yes ◯ No	
Contact phone #	Contact fax #	

Member information (one member only)	
First name	Last name
DOB	Member Oscar ID (OSC#xxxxxxxx-xx)

Please advise if this appeal is related to:		
◯ Pre-service	◯ Concurrent	◯ Post-service

Claim information (one claim ID only)		
Oscar claim ID	DOS Start	DOS End
Billed amount	Procedure code(s)	

Clinical appeal- please attach medical records as supporting documentation to enable review	
Denied authorization ID: (if available) _____	
Date of auth denial: (if available) _____	
Select one clinical appeal category:	
◯ Medical necessity	◯ Experimental / investigational procedure

Explanation (state the reason for the appeal, and expected outcome, below)

Supporting documentation (please list attached clinical documentation to be considered during the review of this appeal, such as written comments, documents, records, and material relating to this appeal)
If clinical documentation is not initially attached, Oscar will have to request medical records to review your appeal.

Please send your completed form and supporting documentation via one of the following methods:

- Fax: 1-844-965-9054
- Mail: Oscar Health, Inc. P.O. Box 52146 Phoenix AZ, 85072–2146.