IncentiCare Health Results Appeal Form

Submit this form to **benicomp.com/appeals** within 30 days of your plan start date. Section B and C of this form must be completed by your Primary Care Provider. **All sections must be filled out/completed.**

Your appeal will be evaluated by BeniComp's Preventive Health Management Team, and you will be notified of the status.

Section A: Member Information

Full legal first name:

Full legal last name:

Date of birth: (MM/DD/YYY)

Employer name:

Address

City:

State:

ZIP code:

Last 4 digits of Social Security Number:

Email address:

Do you have a cell phone?

Yes ☐ No ☐

If yes, cell phone number:

___ - ___ - ____

BENICOMP INSURANCE COMPANY

Section B: Physician Information

Physician full name (printed):

NPI: (National Provider Identifier #)

Practice name:

Visit/test date: (MM/DD/YYYY)

Practice street address:

State:

ZIP code:

City:

Practice phone number:

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By signing, I verify that the information supplied by myself or my representative here is true and complete. I also understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files, a statement of claim, or an application containing any false, incomplete, or misleading information will be subject to criminal penalties applicable to state laws.

Physician's Signed Agreement:

Participant's Signed Agreement:

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Section C: Appeal Information

Part 1:

Fill out this section, if you are appealing a result(s) because it is **incomplete or inaccurate**. If it is medically unadvisable for you to meet an optimal range for one or more biomarkers, skip Part 1 and go to Part 2.

Part 1(a): Fill out if you are appealing BMI or blood pressure

Check the biomarker(s) being appealed and provide the biometric requirement(s).

☐ **Body Mass Index (BMI)**

Date of measurements listed below must be within 30 days of company Health Screening.

Height (inches)

Weight (lbs)

BMI

(Optional) additional supporting measurements:

Waist circumference

Hip circumference

Body fat percentage

*If you are appealing due to having a muscular build, being pregnant, or having any disability affecting your BMI measurement, please fill out *Section C, Part 2.*

☐ **Blood pressure**

Provide a record of the last 3 readings of the member's blood pressure.

Reading 1 | *Visit Date*

Reading 2 | *Visit Date*

Reading 3 | *Visit Date*

*If the member Is on blood pressure medication, blood pressure must be controlled (<130/80) or within range for an appeal to be approved. Please provide additional detail In *Section C, Part 2.*

*In order for your Blood Pressure appeal to be approved, Health Screening results must indicate member Is Nicotine/Cotinine negative.

Part 1(b): Fill out if you are appealing blood glucose, LDL, or Nicotine

Check the biomarker being appealed and attach the appropriate document(s). Blood Glucose, LDL Cholesterol, and Nicotine/Cotinine require documentation of a re-test from a certified lab.

☐ **Blood Glucose**

Please provide results of a re-test from a certified laboratory or laboratory results date marked within 30 days of your Health Screening event from a certified laboratory.

*Fasted blood glucose required, additional A1c results preferred.

☐ **LDL Cholesterol:**

Please provide a re-test from a certified laboratory or laboratory results date marked within 30 days of your health screening event from a certified laboratory.

Please provide your new triglyceride health result alongside your new LDL result.

☐ **Nicotine/Cotinine**

This is not a smoking attestation.

Please attach a re-test from a certified laboratory or laboratory results date marked within 30 days of your health screening event from a certified laboratory to this form.

If you are completing a smoking cessation program you are ineligible to earn the appeal until that program has been complete and you can provide updated results. Claims incurred prior to the date of retest will not be reimbursed.

Part 2:

Fill out this section, if you are appealing a result(s) because the company's target goal is **medically inadvisable** for the member.

(1) List the biomarker being appealed

(2) Physician's explanation of why this target goal is medically inadvisable for the patient:

(3) If applicable, is the member on any medication or action plan to regulate this biomarker?