How to Appeal a Denial
General Tips

If we deny a claim or a request from your provider for prior authorization of services and you do not agree, you can ask for a review. This is called an appeal. You will find the complete process outlined in the section of your policy titled Claims Appeal Procedures.

Please refer to your Policy Terms and Conditions located within your member portal for more information on how to appeal a denied claim.

Please note that you have 60 days to file an appeal. You must submit your request in writing along with the Member Appeal Form.
You may send your appeal via email to conciergecare@payerfusion.com or postal service to our Plan Administrator:

PayerFusion Holdings, LLC
2100 Ponce de Leon Boulevard
Mezzanine Level
Coral Gables, FL 33134

You may appeal on your own or you may authorize someone to appeal for you. This is called an authorized representative. Please complete the Appeal Patient Consent Form.

How long do I have to ask for an appeal?
The amount of time you have to file for an appeal varies from product to product. Each of our policies specifies the number of days from when you receive the notice of the denied claim or the denial of the request for prior authorization to submit your appeal.

What should the request include?
In your appeal, you should explain the reasons for your appeal and include all information to support your request. You should also include (if applicable):

- Your policy number
- Your name *(and the name of the member you are appealing for if it is not you)*
- Your member ID number located on your member ID card
- The provider's name
- The date of service
- The type of service
- The Explanation of Benefits (you can obtain your EOB from your member portal or contact ConciergeCare on the phone number listed on your member ID card. We will send it to you free of charge.)
- Any other documents, records or other information you would like us to consider.

Please note that any costs for medical records or other documentation in support of your appeal will be at your sole expense. It is the member's responsibility to provide all information in support of the appeal. We will not be able to begin our review until we receive all of your information. If we do not receive the information requested for your appeal, the appeal will be closed until the required information is provided to us. If we do not receive the required information within the number of days specified in your Policy, from the date of the denial of your claim or pre-authorization, the decision will stand (with non-payment or no prior authorization approval) and the appeal file will be closed.

How long will it be before WellAway makes a decision?
Please refer to your Policy.

We are always available to answer any questions.

Phone: ConciergeCare +1-855-773-7810 or +1-786-453-4008
Email: conciergecare@payerfusion.com