HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

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Appeal Request Form for Providers

This form is to dispute a determination made by HWMG. For information regarding appeals and the dispute resolution process, refer to the Administrative Manual for Participating Providers.

Provider Information

Provider Last Name	First Name	MI	Suffix and Title

Practice Name (if different from Provider named above)	Taxpayer Identification Number

Contact Person and Job Title for Appeal Correspondence (if different from above)	Office Name	Phone/Fax/Email

Mailing Address for Appeal Correspondence	City	State	Zip Code

Patient Information

☐ **Does Not Apply**

Patient Last Name	First Name	MI	Suffix

Patient Date of Birth (mm/dd/yy)	Policy Number	Member ID Number

Reason for Request – If additional space is required, please attach a separate sheet. Include all relevant documentation supporting your request for HWMG to consider.

Are you providing supporting documentation not previously reviewed by HWMG? ☐ Yes ☐ No	When was provider first informed of HWMG's decision that led to this request? (mm/dd/yy)	What was the claim or precertification number(s) provided by HWMG?

Date(s) of Service	Diagnosis/Procedure Codes and/or Type of Service (e.g., survey, lab, office visit)

Explain the issue to be resolved.

Select the category of your request:

☐ **Administrative matters.** We must receive your written appeal request within **one year** from the date that the provider was first informed of the determination in dispute (e.g., denial or limitation of your claim, or the denial of coverage for a requested service upon a precertification review). This one-year deadline applies whether or not the provider filed a request for reconsideration of the initial determination, and whether or not that request is pending at the time of this one-year deadline.

Select the subcategory of your request:

- ☐ **Claims denial, payment, eligible charge, or coverage**
- ☐ **Precertification/authorization for medical services rendered in Hawaii**
- ☐ **Other, please specify:** _____

☐ **Network termination or action related to a provider's professional competency.** We must receive your written appeal request within **60 days** from the date the provider was first informed of the determination in dispute.

By my signature below, I certify the information contained in this form is complete to the best of my knowledge.

Signature of Requestor	Print Name	Date (mm/dd/yy)

Requestor's Relationship to Provider (if requesting on behalf of the Provider named above)

Return this completed and signed form to **HWMG, Attn: Appeals Coordinator**.
Contact information is shown at the top of this form.