EVO APPEAL PROCESS

Our Process for Disputes and Appeals

Any active Evo member, health care provider, or pharmacy may request an appeal after a coverage determination or prior authorization has been denied. The appeal must reach Evo no later than 180 days after receipt of the adverse determination. It must include reasons for the disagreement with the original decision, as well as any pertinent new information.

- For expedited, *urgent appeals, best efforts are made to review submissions within 24 hours of receipt and written confirmation is sent to the member and prescriber within 72 hours.
- If the original determination is upheld, the written notification will include the principal reason(s) and information on how to file an external appeal.
- If the determination is overturned, Evo will notify the member and prescriber in writing and enter an override in our system.

Please note that all denials where an appeal may arise are either based on medical criteria for coverage exclusions established by the Plan or on approved FDA indications. The appeal may be forwarded to the Plan Administrator for review and determination.

* A request is deemed urgent when the prescriber believes the member's health, life, or ability to regain maximum function may be seriously jeopardized under the standard review timeframe.

Instructions

To request an appeal, complete the appeal form and submit it to Evo by email or fax. Alternatively, you have the option to complete a secure webform on our website.

Attn: Evo First Appeals
Email: appeal@evofirst.com
Fax: 844-386-0001
Online: www.evofirst.com/appeal

To help us resolve the dispute, we'll need:

1. A completed appeal form.
2. The reasons why you disagree with the original determination.
3. Supporting documents such as medication history, diagnostic workup, lab results, chart notes, etc.

EVO APPEAL FORM

Appeal Form

Complete all fields. Please be specific and detailed. Provide any new or additional information to support the appeal such as medication history, diagnostic workup, lab results, chart notes, etc.

Today's Date: _____

Drug Requested: _____

Member's Name: _____

Date of Birth: _____ Phone #: _____

Group Name: _____ Member ID #: _____

Please explain why this medication is medically necessary for the patient:

_____

_____

_____

_____

_____

Provider Information

Provider Name: _____ NPI #: _____ Phone #: _____

Provider Address: _____ City, State, Zip Code: _____

Person requesting the appeal:

Name: _____ Signature: _____