P4P Results Appeal Form

To be completed by Physician Group or Health Plan requesting appeal:

Date: _____

Name of person submitting the appeal: _____

Phone number and e-mail of person submitting the appeal: _____

_____

Name of organization: _____

DMHC number (for physician groups): _____

Please explain the facts of this appeal. What was wrong with the final results communicated to you? Explain the what, where, when, and how. Include how the error was discovered and steps you have subsequently taken. Please attach any correspondence and documentation that you believe support your appeal.

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Submit completed form and supporting documents to:

Dolores Yanagihara, Integrated Healthcare Association, dyanagihara@iha.org
344 Thomas L. Berkley Way, Suite 350, Oakland, CA 94612
FAX: 510-444-5842

DEADLINE: June 29, 2007

To be completed by Integrated Healthcare Association:

Date Received: _____
Received by: _____