FOR PROVIDER USE ONLY

REQUEST FOR EXTERNAL INDEPENDENT THIRD PARTY REVIEW

Providers must use this form to request an External Independent Third-Party Review. Members may not request an External Independent Third-Party Review due to payment requirements. All fields below are required. Please submit the completed form via mail or fax:

Sunflower Health Plan – Appeals Department
8325 Lenexa Drive, Suite 410
Lenexa, KS 66214
Fax 1-888-453-4755

Member's Name: _____

Medicaid #: _____

Authorization, Claim, or Tracking Number you wish to dispute:

Basis upon which you believe Sunflower's decision to be erroneous:

With my signature, I am requesting an External Independent Third-Party Review. **I understand that I am responsible for payment of the cost of the review if the decision I am disputing is not reversed by the third-party review.**

Provider's Signature: _____

Printed Provider's Name _____

Designated Contact Name: _____

Mailing Address: _____

Daytime Phone #: _____ Fax #: _____

Email Address: _____

Requests for External Independent Third Party Review will be denied if the provider has not completed the Sunflower appeal process, does not request the external review within 63 calendar days, or does not complete this form in its entirety.