<Plan name>

APPEAL REQUEST FORM

Mail this form to: <Address>
<City, State Zip>

Fax to: <Fax number>
Email to: <Email address>

Participant Information [*the plan should auto-populate the Participant's Information*]

Name: <First Name> <MI> <Last Name>
Participant ID: <Participant ID>
Address: <Address> <City, State Zip>
Home Phone: <Home Phone> Cell Phone: <Cell Phone>
Date of Birth: <DOB>

Requester (if different from above)

Name: _____ E- mail: _____

Address: _____ Fax #: (_____)_____

City: _____ State: _____ Zip Code: _____ Phone #: (_____)_____

Does the Requester intend to represent the Participant? ☐ YES ☐ NO

Appeal Information

Today's date: _____ Service you are appealing: _____

_____

Reason for requesting appeal: _____

_____

_____

☐ I request an In-Person Review. If checked, is member homebound? ☐ YES ☐ NO

☐ Is an Interpreter needed? ☐ YES ☐ NO Language: _____

☐ I need an accommodation for my disability for this appeal. The accommodation(s) I need are:

_____

☐ I enclosed additional documents for consideration for the appeal.

☐ I request a FAST APPEAL because my health could be seriously harmed if the decision takes 30 days.

☐ I request copies of my medical record and any documentation used to make the determination. Please send these documents to:

☐ Me ☐ My representative (see above)

☐ I request the clinical guidelines and/or other rules or regulations used to make my determination. Please send these documents to:

☐ Me ☐ My representative (see above)