A Qualified Health Plan Issuer in the Health Insurance Marketplace
P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com

INTERNAL APPEAL REQUEST FORM

Name of person filing appeal: _____

Relationship to covered person: ❒ **Covered Person/Applicant**
❒ **Authorized Representative (please complete the Appointment of Authorized Representative section)**

How would you like us to contact you? ❒**Phone** ❒**Fax** ❒**Email** ❒**Mail**

Internal Appeal Specifications

1. **Are you requesting an Expedited Internal Appeal because you are currently hospitalized?**

   ❒**YES*** ❒**NO**

2. **Are you requesting an Expedited Internal Appeal because in the opinion of your treating provider, review under the standard Internal Appeal time frame (of up to 30 days) could, in the absence of immediate medical attention, result in placing your health or the health of your unborn child in serious jeopardy, cause serious impairment of your bodily functions, or cause you serious dysfunction of a bodily organ or part?**
   ❒**YES*** ❒**NO**

3. **Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review that in** your treating provider's opinion is necessary? **(Note: Request for External Review form is not required.)**
   ❒**YES*** ❒**NO**

***If you answer YES to any of the questions above, your treating provider must complete the Treating Provider Opinion Form for Internal Appeal and/or External Review.**

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or oth**er documents to support your claim):**

_____

_____

_____

Covered Person/Applicant Information

Name: **ID Number:**

Mailing Address:

Daytime Phone: **Evening Phone:**

Email Address: **Fax:**

Treating Physician/Health Care Provider Information

Name:

Mailing Address: **Phone Number:**

Email Address: **Fax Number:**

Contact Person: **Phone Number:**

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating provider, to act as your authorized representative. You may revoke this authorization at any time.

I, _____, appoint _____,
Your Name Your Authorized Representative's Name

to act on my behalf in connection with any claim for coverage or benefits identified in this case, including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me and to provide any information to the health plan in relation to the disputed claims, approvals, or authorizations.

_____

Signature of Covered Person (or legal representative*) **Date**
***Parent, Guardian, Conservator, Other—please specify**

I,_____, hereby accept the above appointment.
Name of Representative

I am a/an _____.
Relationship to insured

_____

Signature of Authorized Representative **Date**

Contact information of authorized representative (if applicable)

Mailing Address:

Daytime Phone: **Evening Phone:**

Email Address: **Fax:**

Consent to Release Medical Records

To request an Internal Appeal and/or an External Review of your Adverse Benefit Determination, whether expedited or not, you must sign and date this form and consent to the release of your medical records.

I, _____, hereby request an Internal Appeal and/or External Review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, health care provider, and/or health plan issuer to release all relevant medical or treatment records to the Independent Review Entity, the Department of Insurance, and/or my health plan issuer. I understand that the Independent Review Entity and/or my health plan issuer will use this information to make a determination on my Internal Appeal and/or External Review and that the information will be kept confidential and not be released to anyone else. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____

Signature of Covered Person (or legal representative) Date**

****Parent, Guardian, Conservator or Other - please specify**

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO FOLLOWING ADDRESS OR FAX IT TO:

Fax Number: 1-866-582-0614

Mailing Address: CareSource, Attn: Member Appeals, P.O. Box 1947, Dayton, OH 45401-1947

Be certain to keep copies of this form, your Notice of Adverse Benefit Determination, and all documents and correspondence related to this claim.

Please submit a billing statement along with this form if you are requesting a standard appeal for claim denial or if you are disputing a claim payment.

If you need help with this form, please call our Member Services department at the telephone number listed on your ID card. Member Services is open Monday through Friday, 7 a.m. to 7 pm.

AM-EXCM-0786