CareSource Health Care with Heart | Ohio Department of Medicaid Next Generation MyCare

Member Standardized Appeal Form

Complete Sections I and II of the form entirely, describe the issue(s) in as much detail as possible, and submit it to CareSource. To ensure a decision can be made by CareSource, the following documentation should be submitted with the form:

- Attach copies of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

Section I – Member Information	
Member Name:	**Date of Birth** (mm/dd/yyyy):
Member ID Number:	**Member Phone Number:**
Member Address:	
Date of Request (mm/dd/yyyy):	**Request Type:** ☐ Grievance/Complaint ☐ Appeal

Section II – Description of Specific Issue Please state all details relating to your request including names, dates, and places. Attach another sheet of paper to this form if more space is needed.

By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Member's Signature:	**Date** (mm/dd/yyyy):
Member's Authorized Representative Name (if applicable):	**Authorized Representative Signature** (if applicable):

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling 1-800-488-0134; individuals with a hearing impairment may call 711.