Kentucky Medicaid MCO
Member Appeal Request

Check the box of the plan in which the member is enrolled	MCO	Phone	Fax
	☐ Anthem BCBS Medicaid	1-855-661-2027 Ext. 26740	1-855-443-7820
	☐ Coventry Cares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	☐ Humana – CareSource	1-877-892-7487	1-855-262-9794
	☐ Passport Health Plan	1-800-578-0636	502-585-8461
	☐ WellCare of Kentucky	1-877-389-9457	1-866-201-1657

Please complete all appropriate fields

If you need assistance with this form, call your MCO at the number listed above
All Appeals must be filed within 30 days from the date of MCO action

Date _____

Person filing request _____ **Email** _____ **Phone** _____

☐ **I am a Medicaid member** ☐ **I am filing request on behalf of a Medicaid member**

If filing on behalf of member, state relationship to member _____

Who is the Appeal for?

Member's name_____

Member's Social Security Number_____ Member's DOB_____

Member's address _____ County _____

Why are you requesting an appeal?

Procedure or Service you are requesting_____

Doctor or Provider of service _____ Phone_____

Doctor or Provider address _____

Reason for procedure/service _____

Please give as much detail as possible about this request:

Attach a copy of the denial letter along with any other correspondence concerning this request.

☐ **By signing this document, I authorize the person submitting this form to do so on my behalf**

Signature of Member_____ Date _____

Signature of person filing request _____ Date _____

Members have the right to request a continuation of benefits while the Appeal is being processed

This form complies with the Appeal process as outlined in KAR 17:010