MEMBER APPEAL REQUEST FORM

Is this request for an Expedited Appeal?: *Are you requesting an Expedited Internal Appeal because in the opinion of your treating provider, review under the standard Internal Appeal time frame 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 or ❒No

Name of person filing appeal: _____

Relationship to covered person: (Pick One)

❒ Covered Person/Applicant

OR

❒ Authorized Representative (please complete the CareSource Appointment of Representative Form)

What is being Appealed:

Date of Service(s) and/or Claim Number(s) of Claim Denial (if applicable):

_____

Prior Authorization Number(s) Denied (if applicable): _____

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

_____

_____

Covered Person/Applicant Information

Name: **ID Number:**

Mailing Address:

Phone:

Email Address:

Treating Physician/Health Care Provider Information

Name:

Mailing Address:

Fax Number:

Contact Person:

Phone Number:

1. **Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review that** in your treating provider's opinion is necessary? ❒**YES*** **or** ❒**NO**

Signature:

_____

(Signature of Covered Person or Authorized Representative) **(Date)**

***Please note**: **If someone other than the Covered Person is filing this request then they must also include a signed and completed CareSource Appointment of Representative form with this request.**

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 Kentucky 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 AND THE CARESOURCE APPOINTMENT OF REPRSENTATIVE FORM (IF APPLICABLE) TO ONE OF THE FOLLOWING:

Fax Number: 937-531-2398
Mailing Address: CareSource, Attn: Member Appeals, P.O. Box 1947, Dayton, OH 45401-1947

If you need help with this form, you may call the Member Services departments for your state, Monday through Friday, 7:00 a.m. to 7:00 pm:

Georgia Marketplace Members: 1-833-230-2030

Indiana Marketplace Members: 1-877-806-9284

Kentucky Marketplace Members: 1-888-815-6446

Ohio Marketplace Members: 1-800-479-9502

West Virginia Marketplace Members: 1-855-202-0622

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