A Qualified Health Plan Issuer on 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

Contact information of authorized representative (if applicable)

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

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:

continued

Internal Appeal Specifications

1. Are you requesting an expedited appeal because your health, life or ability to regain maximum function may be in serious jeopardy while you wait up to 30 days for a decision on your appeal? ❒ YES ❒ NO

2. Are you requesting an expedited appeal because your physician certifies that your pain cannot be controlled while you wait up to 30 days for a decision on your appeal?
❒ YES* ❒ NO

3. Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review and your physician certifies that it is necessary? (Note: Request for External Review form is not required.) ❒ YES* ❒ NO

*If you answer YES to question 2 or 3 above, your physician must complete the Treating Physician Certification Form for Internal Appeal and/or External Review. You may also have your physician complete the certification form if you answer YES to question 1.

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):

_____

_____

_____

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 health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize_____to pursue my appeal on my behalf.

_____

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

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I_____hereby request an appeal. 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 an independent review organization, the Ohio Department of Insurance, and/or my health plan issuer. I understand that the independent review organization, the Ohio Department of Insurance, and/or my health plan issuer will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. 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 ONE OF THE FOLLOWING ADDRESSES:

Fax Number: 937-487-0629
Mailing Address: CareSource, Attn: Member Appeals, PO Box 1947, Dayton, OH 45401

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

If you need help with this form, please call our Member Services department at **1-800-479-9502**, Monday through Friday, 7:00 a.m. to 7:00 p.m.

OH-EXCM-0438