MEMBER APPEAL REQUEST FORM

Member Information

Member Name: Member ID Number:

Mailing Address:

Phone:

Email Address:

Name of person filing appeal: _____

Relationship to member: (Check One)

I am the member ☐ OR ☐ I am the Authorized Representative Appealing on behalf of member.

(Please complete and submit the Appointment of Representative Form with this appeal)

Authorized Representative's Information

Phone Number:

Mailing Address:

Fax Number:

Email address:

What is being Appealed?

Describe in detail why you disagree with this decision and tell us how you want us to resolve your request. You may attach information, such as a provider letter, bills from providers exceeding your plan copay, coinsurance, and/or deductible, medical records, or other items to support your request:

Date of Service(s) and/or claim number(s) of claim denial (if applicable):

_____

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

Treating Physician/Health Care Provider Information

Name:

Mailing Address:

Fax Number:

Contact Person:

Phone Number:

Is this request for a Standard or Expedited (Urgent) Appeal?

☐ Standard Review

☐ Expedited Internal Appeal

In your treating provider's opinion, is an expedited review necessary? ☐YES* or ☐NO

*If yes, are you requesting an Expedited Internal Appeal or Expedited External Review 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

Signature:

_____

(Signature of Member or Authorized Representative) (Date)

Note: If someone other than the member is filing this appeal, they must also include a signed and completed *Appointment of Representative* form with this request.

SUBMIT THIS FORM AND ALL RELEVANT DOCUMENTS RELATED TO YOUR COMPLAINT, INCLUDING A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION AND THE APPOINTMENT OF REPRSENTATIVE FORM (IF APPLICABLE), USING ONE OF THE FOLLOWING:

- Online using your CareSourceMyLife account at MyLife.CareSource.com
- Mailing Address:

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

If you need help with this form, call Member Services at **1-877-514-2442** (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m. Central Time (CT).