Member appeal submission form

To be considered a valid appeal, the Member Response Coordinator must receive it within 180 days of the final adverse decision of the plan.

Submitter's information

Name	Member ID or provider number

Member's contract information

Name	ID number	Phone	

Email	Can we contact you by email? ☐ Yes ☐ No

Street or PO box	City	State	ZIP

Patient and provider information

Name	Date of service

Name of physician, hospital or other	Claim number or reference number, if any

Please check one or more of the following reasons for the appeal:

- ☐ Disagree with the amount paid on a claim or with the amount of member copay/coinsurance
- ☐ Urgent or emergency claim denial
- ☐ Services denied as not medically necessary/ does not meet criteria
- ☐ Services denied as a pre-existing condition (please provide any previous insurance information)
- ☐ Claim denied for not obtaining a prior authorization
- ☐ Denial of Prior Approval of a service, test, equipment, or drug
- ☐ Eligibility issue
- ☐ Other: _____

Please explain (Please feel free to attach any medical records or a narrative explaining your appeal):

Providers: Did the member sign a valid specific waiver for the denied procedure? ☐ Yes ☐ No

If a valid waiver was signed, please attach with the appeal request.

Are you requesting an expedited or urgent appeal? Urgent appeals should be requested when a request for a health care service or treatment or prescription drug was denied and you believe the denial would seriously jeopardize your life or health or your ability to regain function. You may support your request for an expedited appeal by having your ordering physician attest to this request in the section below.

My signature attests to the position that the time for a standard review (15 days in this case) would seriously jeopardize the member's health, life or his/her ability to regain function.

Ordering physician signature	**Date signed** (mm/dd/yyyy)

Please return this signed form to:
Health Advantage
ATTN: Member Response Coordinator
P.O. Box 8069
Little Rock, AR 72203

Fax: 501-212-8518

Email: appeals@healthadvantage-hmo.com