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: (Circle One)

Covered Person/Applicant OR Authorized Representative *(please complete the HAP 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: Member ID Number:

Mailing Address:

Phone:

Email Address:

Treating Physician/Health Care Provider Information

Name:

Mailing Address:

Fax Number:

Contact Person:

Phone Number:

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 *HAP 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 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 HAP CARESOURCE APPOINTMENT OF REPRSENTATIVE FORM (IF APPLICABLE) TO ONE OF THE FOLLOWING:

File using your **MyCareSource.com** account

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

If you need help with this form, you may call Member Services Monday through Friday, 7:00 a.m. to 7:00 p.m. Eastern Time (ET) at **1-833-230-2099** (TTY: 711).

MI-EXC-M-2938524