**Medical & Part D Appeal Request Form**

If you disagree with the decision for a request for coverage or payment for a service, you have the right to ask us for a reconsideration/redetermination (appeal) of our decision. You have 60 days from the date of our notice of denial to ask us for an appeal. You may also ask us for an appeal through our website

**Who May Make a Request:** In addition to you**,** your physician/prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. To appoint another person to act as your representative, contact Customer Service and request an “Appointment of Representative” form.

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| Member Name: Click or tap here to enter text. | ID#: Click or tap here to enter text. | DOB: Click or tap here to enter text. |
| Requestors Name (if other than member): Click or tap here to enter text. |
| Relationship to member: Click or tap here to enter text. |
| *If representing the member, the first 3 lines of information should be your information.* |
| Address: Click or tap here to enter text. |
| City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip: Click or tap here to enter text. |
| Telephone #: Click or tap here to enter text. |
| What you are appealing: Click or tap here to enter text. |
| Reference/Claim #: Click or tap here to enter text. |
| Date of Service (if applicable): Click or tap to enter a date. | Date of Decision Notice: Click or tap to enter a date. |
| *For Part D Requests, fill in the below 5 lines* |
| Prescriber Name: Click or tap here to enter text. | Office phone: Click or tap here to enter text. |
| Name of drug: Click or tap here to enter text. | Strength/quantity/dose: Click or tap here to enter text. |
| Have you purchased the drug pending appeal? [ ]  Yes [ ]  No |
| If “yes” - Date Purchased: Click or tap to enter a date. | Amount paid: Click or tap here to enter text.(attach copy of receipt) |
| Name and telephone number of pharmacy: Click or tap here to enter text. |
| Please indicate the reason for the Medical or Part D appeal: Click or tap here to enter text.*(Use the back of this form if you require more space)* |
| Is there additional information we should consider when reviewing this appeal?Click or tap here to enter text. |
| **Important Note: Expedited Decisions**Medical Item/Service - If you believe that waiting 30 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. You cannot request an expedited appeal if you are asking us to pay you back for service/item you already received.Medicare Prescription Drug - If you believe that waiting 7 days for a standard prescription drug decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision.[ ]  CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS. Expedited appeal requests can also be made by phone at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 5 p.m. local time.  |
| Signature:  | Date: Click or tap to enter a date. | Time: Click or tap here to enter text. |

Please mail or fax completed form to:

ATRIO Health Plans

Appeals and Grievances

**PO Box 5600**

**Scranton, PA 18505**

Fax: 1-866-339-8751

For assistance with this form or questions regarding your appeal, please contact our Customer Service department at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.