COMMUNITY Health Options™

Member Appeal Form

BEFORE PROCEEDING, NOTE THE FOLLOWING:

- This form is only used for requesting a formal appeal of any adverse determination.
- For Express Scripts Pharmacy appeals, please contact Express Scripts directly at (800) 282-2881.
- This form is only for use by Members enrolled in a fully-insured plan from Community Health Options. If you are a Member of a self-insured employer plan administered by PioneerASO, please use the PioneerASO Member Appeal Form.

INSTRUCTIONS:

Please fill in as many of the fields on this form that you are able, attach supporting documentation and submit everything to us via mail, secure email, or fax by using the address or fax number at the end of this form. Appeals must be submitted within 180 calendar days of: the date of the Explanation of Benefits (EOB); or, 180 calendar days of the date on the denial letter or correspondence. Please allow up to 30 calendar days from the date your appeal is received for Community Health Options to process your appeal. We will mail a letter to you to acknowledge that we have received your appeal within 3 business days of the receipt date.

REQUESTS FOR APPEAL SHOULD INCLUDE:

1. This signed form including the reason(s) why you believe the adverse determination is incorrect and should be changed.
2. Supporting documentation that you feel will assist us in reviewing your appeal.

MEMBER INFORMATION			
Member ID:		Claim #:	
Date of Service:	Billed Amount:	Authorization #:	
Member Name – Last:		First:	MI:
Member Date of Birth (DOB):		State:	ZIP:

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION		
Physician, Provider or Practice Name:		
Practice Address:	State:	ZIP:
Contact Person:		
Amount Owed (Optional):		

Please select the issue that best describes your appeal. The initial decisionwas related to:

- ☐ Claim processing
- ☐ Out of pocket / deductible / co-insurance amounts
- ☐ Medical necessity
- ☐ Other (please indicate):

CONTINUED ON NEXT PAGE

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State the reason for the appeal and expected outcome below and attach supporting documentation.

Has anyone at Health Options tried to resolve the situation? If yes, please explain and provide the reference number(s) associated with the contact or call.

Name of Requestor:	Relationship to Member:
Phone #:	Email Address:
Address (for notices regarding this request):	
Signature:	Today's Date:

Mail, fax, or scan and e-mail this completed form along with all supporting documentation to:

E-mail: appeals@HealthOptions.org
Please utilize a secure email method only, to protect your private information. Check with your email provider if you are unsure if your email is considered secure.

Fax: (877) 314-5693

Mail: MAIL STOP 800
ATTN: APPEALS
COMMUNITY HEALTH OPTIONS
P.O. BOX 1121
LEWISTON, ME 04243-1121