MEMBER APPEAL FORM



NetCare Health will accept your request for an appeal when the request is submitted within **180 days of receipt of a denial notice.** If more than 180 days have passed since you were notified, and you still have a question, please call Customer Service using the number on the back of your member ID card.

An appeal is a request to change a previous adverse decision made by NetCare Health. You or your representative (including a physician on your behalf) may appeal the adverse decision related to your coverage.

Complete and mail this form and/or appeal letter along with any supporting documentation to the address identified below.

REQUESTS FOR AN APPEAL SHOULD INCLUDE:

- 1. If you submit a letter without a copy of the Member Appeal form, please specify in your letter this is a "Member Appeal". Please include all the information that is requested on this form.
- 2. Any documentation supporting your appeal. For adverse decisions based upon lack of medical necessity, additional documentation may include a statement from your healthcare professional or facility describing the service or treatment and any applicable medical records.

Subscriber's Name (Last) (First)	(MI)	Subscriber ID Number
Subscriber's Mailing Address		Phone Number
Member's Name (Last) (First)	(MI)	Date of Birth
Health Care Professional or Facility Name	Date of Service	Claim Number /Authorization Number
Appeal is being filed by: Appeal is being filed by: Subscriber Spouse Child Other Note: If your selection is spouse, child (18 years of age or older) or other, please complete and include the attached Authorized		
Representative Form with your request. Name of person filling out the form		Today's Date
Signature		Phone Number
Please Explain the Reason Why You're Appealing <i>(Use additional pages if necessary.)</i>		