Member Claim Appeal Request Form

Magellan Healthcare, Inc. (Magellan) members and their authorized representatives have the right to disagree with certain decisions we have made by asking for an appeal (42 CFR § 435.923). All claim appeal requests must be submitted (whether orally or in writing) within 60 calendar days from the denial letter date. Magellan will notify you and/or your authorized representative (if applicable) of our decision within the timeframes below.

If you would like someone else to request the appeal of the claim on your behalf, such as a representative like a family member or friend, you must provide written consent for that person to do so. Please see the section below titled **Consent for a representative to file a claim appeal on your behalf** where you can give us your consent. If you would also like Magellan to be able to share information about you to that person, you will also need to complete the attached Authorization to Use/Disclose Protected Health Information (PHI) form (AUD).

How to request a claim appeal:

1. Fill out and sign the form below. If you want to have someone submit your claim appeal for you, complete the **Consent for a representative to file a claim appeal on your behalf** section on this form. If you also want to authorize Magellan to share your PHI with this person, you will also need to complete & submit the attached Magellan AUD form. You may want to keep a copy for your records.

2. Fax, email, or mail the request within 60 calendar days of the Adverse Benefit Determination (ABD) date.
   - **Email**: IDAC@magellanhealth.com
   - **Mail**: Magellan HealthCare, Inc.
     P.O. Box 2188
     Maryland Heights, MO 63043
   - **Fax**: 1-888-656-9795

3. A claim appeal can be also requested verbally by calling Magellan at 1-855-202-0973 (TTY 711), available 8 a.m. to 6 p.m. Mountain Time.

Where can we contact you?				Your (Member's) Name	Your (Member's) Email Address	
Phone Number	Can we leave you a voicemail?	Yes	No	Member's Date of Birth	Member ID#	
Street Address				City	State	Zip Code

Source: U.S. Department of Health and Human Services, Office for Civil Rights, August 2016

What are you appealing?

Provider Name				
Provider Street Address		Provider City	Provider State	Provider Zip Code
Reason for your claim appeal.				
Claim 1 (see information listed on the ABD)				
Claim #	Line #	Service	From Date	To Date
Claim 2 (see information listed on the ABD)				
Claim #	Line #	Service	From Date	To Date
Claim 3 (see information listed on the ABD)				
Claim #	Line #	Service	From Date	To Date
Claim 4 (see information listed on the ABD)				
Claim #	Line #	Service	From Date	To Date
Claim 5 (see information listed on the ABD)				
Claim #	Line #	Service	From Date	To Date

**You may attach additional pages if your reason for appeal does not fit into the box above.

Source: U.S. Department of Health and Human Services, Office for Civil Rights, August 2016

Standard appeal: We will give you a written decision within 30 calendar days after we get your appeal.

Expedited (Fast) Appeal: We will notify you of our decision within 72 hours of our receipt of your request. An expedited (fast) appeal can be requested **if there is an immediate threat that could jeopardize your life, health, or ability to regain maximum functioning**. Magellan will decide if your appeal meets urgent criteria. We will automatically give you an urgent appeal if your provider supports the urgent request. If an urgent appeal is not granted, we will notify you and give you a decision on your appeal within 30 calendar days.

☐ Check here if you want an expedited (fast) appeal.

Explain reasoning for expedited appeal.

_____	_____	_____
Member signature	Member name	Date

Consent for a representative to file a claim appeal on your behalf: If you want someone else to ask for an appeal on your behalf, you must give them written permission. Please tell us who that person is and sign below to grant permission for them to start your claim appeal request. If you also want us to release your Personal Health Information (PHI) to that person, please complete the Magellan AUD form and submit it along with this form. Please refer to the Member Handbook or call Magellan at 1-855-202-0973 (TTY 711) for more information about allowing someone else to act on your behalf requesting an appeal.

Name of Person Who Can File This Appeal On Your Behalf: _____

_____	_____	_____
Signature of Member/Legal Guardian/Parent if a minor	Printed Name of Member/Legal Guardian/Parent if a minor	Date

Mail, Email, or Fax this Appeal Form, any supporting documents, and the signed AUD Form (if needed) to:

- **Mail:** Magellan Healthcare, Inc., Attn: Idaho Quality Dept, P.O. Box 2188, Maryland Heights, MO 63043
- **Email:** IDAC@magellanhealth.com
- **Fax:** 1-888-656-9795

Please call our Customer Experience Associates if you have questions or need help with completing this form.

- 1-855-202-0973
- TTY: 711

Appeals filed with the Idaho Department of Health and Welfare (known as State Fair Hearings) can be filed only after filing an appeal with Magellan **OR** if you did not receive a Notice of Appeal Resolution Letter within 72 hours from receipt of an expedited (fast) appeal / 30 calendar days from receipt of appeal for a standard appeal.

If you have any questions or need help with this form, please call the toll- free Magellan member line at **1-855-202-0973** (TTY 711), available 8 a.m. to 6 p.m. Mountain Time.

Source: U.S. Department of Health and Human Services, Office for Civil Rights, August 2016