Member 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 appeal requests must be submitted (whether orally or in writing) within 60 calendar days from the denial letter date. Magellan will notify you, your authorized representative (if applicable), and your provider who provided/will provide the care that is the subject of your appeal of our decision within the timeframes below.

If you would like someone else to request the appeal on your behalf, such as your provider or 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 provider or representative to 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), unless the person you indicate is your provider who provided or will provide the care that is the subject of your appeal.

How to request an appeal:

1. Fill out and sign the form below. If you want to have someone submit your appeal for you, complete the Consent for a Provider or Representative to 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. Submit this form along with any additional medical records, office notes and other necessary documentation to support your appeal. You are not required to submit additional documents, but you can if you choose to.
3. Fax, email, or mail the request within 60 calendar days of the denial letter date.
   - **Email**: IDAC@magellanhealth.com
   - **Mail**: Magellan HealthCare, Inc.
     Attn: Idaho Quality Department
     P.O. Box 2188
     Maryland Heights, MO 63043
   - **Fax**: 1-888-656-9795
4. An appeal can be also requested verbally by calling Magellan at 1-855-202-0973 (TTY 711).

<table>
<tr><td colspan="4">Where can we contact you?</td><td>Your (Member's) Name</td><td colspan="2">Your (Member's) Email Address</td></tr>
<tr><td rowspan="2">Phone Number</td><td rowspan="2">Can we leave you a voicemail?</td><td>Yes</td><td>No</td><td rowspan="2">Member's Date of Birth</td><td colspan="2" rowspan="2">Member ID#</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="4">Street Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
</table>

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

What are you Appealing?

Requested Services	Dates of Service	Units
		Provider name
Reason for Appeal**		

**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.

How to keep your services during your appeal: Members who get services or benefits through Medicaid, can ask to keep getting those services while they wait for an appeal decision. This applies when a current approval has not yet ended, but services are being stopped or reduced. Appeals must be sent **within 10 calendar days** of the denial letter or the "Effective Date" shown on the denial letter, whichever is later, to continue receiving services. Only you can request this option. If your provider is appealing on your behalf, we cannot continue services while you are under appeal, because Magellan may collect payment from you for those services if the appeal review decision is not in your favor.

☐ Check here if you want to continue receiving services pending an appeal decision.

Member signature	Member name	Date

Consent for a Provider or Representative to 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 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)

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