APPEAL/COMPLAINT REQUEST FORM

MEMBER NAME: _____ **ID#:** _____

NAME OF PERSON FILING APPEAL/COMPLAINT: _____
Check all that apply: ☐ Subscriber ☐ Member ☐ Authorized Representative***** ☐ Treating Physician

*** For "Authorized Representative", the Member must sign here and comply with the note below in order to authorize the representative to act on their behalf:** _____

Note: Signing above does not automatically authorize the representative to proceed on your behalf. A proper HIPAA authorization is required in order for your protected health information to be shared with your representative. If there is no HIPAA authorization on file for this representative, an authorization will be sent to you to execute and return. Your appeal cannot be processed without all properly completed authorizations. Please note that a special authorization may also be required for behavioral health and family planning matters involving a member over the age of 13.

CONTACT INFORMATION OF PERSON FILING APPEAL/COMPLAINT

Address: _____ **Daytime/cell phone:** _____

Email: _____

Briefly describe why you disagree with this decision or the nature of your complaint (you may use the back of the form and attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

_____

_____

I acknowledge that Bright Health employees who need to know information pertaining to the services in question in order to process this complaint will also have access to and may review such information.

_____ _____
Member Signature **Date**

This form and information relative to your appeal/complaint can be sent to the below address:

Fax #: (888) 965-1815 **OR**

Bright Health
P.O. Box 16275
Reading, PA 19612

Reminder: Keep a copy of this form, your denial notice, and all documents/correspondence related to this request.

Urgent appeals are available only for services that have not been provided.

Are you requesting an urgent appeal? ☐ Yes ☐ No *Standard decisions are made within 30 calendar days unless state specific regulations require a more expedient decision.*
If yes, you must have your treating physician check the appropriate box(es) below and sign the certification.
☐ My patient's health would be in serious jeopardy if required to wait for a standard appeal decision.
☐ My patient would experience pain that cannot be adequately controlled if required to wait for a standard appeal.

Certification:

I hereby certify that the above, in my professional opinion, presents an urgent situation requiring that this member's (my patient) appeal be expedited.

_____ _____ _____
Treating Physician Signature **Date** **Phone**

Print Name _____

Authorization to Share Personal Health Information (ASPI)

MEMBER INFORMATION (*Required)

Full Name: Member ID:

TYPE AND AMOUNT OF INFORMATION TO BE SHARED (•Required)

The type and amount of information that I am authorizing to be shared is:

☐ Medical claims information
☐ Pharmacy claims information
☐ Information on authorizations or appeals*
☐ Other (describe):
☐ Everything, except:

PERMISSION TO SHARE MY PERSONAL INFORMATION

I authorize _____ (Bright Health or Provider Name) to share the above listed information with _____ (Person at Organization/Entity) at_____ (address).

EXPIRATION AND REVOCATION OF AUTHORIZATION

I understand that my authorization will remain in effect until my last day of coverage or until: _____ (date), whichever is earlier. I understand that I can revoke/cancel this authorization at any time by sending a letter to Bright Health. I understand that this revocation will not apply to information that has already been released in response to my initial authorization.

RIGHT TO RETAIN A COPY OF THE AUTHORIZATION

I understand that I have the right to retain or receive a copy of this authorization form.

YOUR PERMISSION (•Required)

Signature: _____ Date: _____

☐ Check if you are Parent/Legal Guardian, or Authorized Representative/Power of Attorney (please include documentation with this form)

Note - When you sign this form, you agree to the following: Bright Health and its related companies have permission to share my personal health information to the person or organization listed in the section above, and/or request my personal health information from a specific third-party. I understand that requested records may contain information on specific medical care or claims. They may also contain information created by others.

*This authorization does NOT allow the named delegate to act on my behalf relative to healthcare decisions, appeals, grievances, or enrollment.

WHAT IS THE PURPOSE OF THIS FORM?

You may use this form to grant permission to Bright Health, or one of its affiliates, to share your Personal Health Information (PHI) with a person or organization of your choice. Bright Health may use this form to obtain your permission to request your PHI from a specific third-party, such as a previous insurance carrier or a non-participating provider.

FREQUENTLY ASKED QUESTIONS

How long does the permission last?
Permission to share your PHI ends on your last day as a member of the plan, or when you let us know in writing that you wish to end your permission.

How do I end permission to share my PHI?
You will need to write us (with signature and date) to the address below and retain a copy for your records.

What if I refuse to sign this form?
You are not required to sign this form - your health benefits will not be affected.

What happens to my health information after Bright Health shares it?
Bright Health takes your private information very seriously. Bright Health shares this information only with the persons and for the purposes authorized on this form. However, we can't control what happens to your information after we share it with the person or organization you name on this form.

Send completed form to:

Bright Health
PO Box 16275
Reading, PA 19612-6275
or fax to (888) 965-1815