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 _____