Member Medicare Appeal Request Form

Member Information

Name:_____ ID:_____ Phone:_____

Appeal Information

Type of Appeal: ___Claim (service or item has already been received)
___ Pre-service Standard (service or item has not been received yet)
___ Pre-service Expedited (see page 2 for requirements on 72- hour review)

Claim/Authorization Number(s):

What is the service or item denied?

Why do you feel the service or item should be covered? (You may include additional pages, applicable medical records, or other supporting documentation.)

Signature_____ Date_____

If you are not the member but are filing on his or her behalf, please include documents supporting your legal representation and sign below. This will avoid reviewing delays. Documentation may include a healthcare Power of Attorney or an Appointment of Representative (AOR) form (available at www.brighthealthplan.com/medicare). Physicians requesting pre-service appeals do not need to file the AOR form.

Representative/Physician Name_____ Phone_____

Relationship to Member_____

Send Completed Form To

Bright Health Medicare Advantage – Appeals & Grievances
PO Box 853943
Richardson, TX 75085-3943
or fax to (800)-894-7742

To meet requirements for an expedited (72-hour) review:

- The request must be for coverage of services you have not received yet. Claim appeals will not be reviewed within 72 hours of receipt.
- A standard appeal review may take up to 30 calendar days from receipt. Waiting for a decision during that time could put your health or life in danger.

If you have not received the services you are appealing and feel you need an expedited (72-hour) review, please let us know. A plan physician will look at your medical records and decide if we should make a fast decision. If the physician decides that the requirements for a 72-hour appeal are not met, your appeal will be processed under the 30 calendar day timeframe. However, we will process your request as soon as possible.

If your physician calls us or writes to us to support your request for an expedited review, we will automatically process it under the 72-hour timeframe.

For more information about the appeals process:

If you have questions about how appeals are processed, please refer to your Evidence of Coverage. You can also visit our website at BrightHealthPlan.com/Medicare or call Member Services at 844-202-4463, 8 am-8 pm MST, 7 days a week Oct. 1-Feb. 14, Monday-Friday Feb. 15-Sept. 30, TTY: 711.

Provider payment disputes should use Bright Payment Dispute Form

Bright Advantage and Bright Advantage Plus are Medicare Advantage plans with a contract with the Federal government. Enrollment in the plan depends on contract renewal. Our plans are issued through: Bright Health Insurance Company of Alabama, Inc.; Bright Health Company of Arizona; Bright Health Insurance Company.

Other providers are available in our network. Most network providers participate through our Care Partner, Arizona Care Network.