HIGHMARK. Delaware HEALTH OPTIONS

Member Appeal Form

Date: _____

Member Name: _____ **Member ID #:** _____

Parent/Guardian: _____ **Relationship:** _____

Address: _____

Phone #: _____ **Completed by:** _____

The following questions will help us understand your appeal. If you need help, please call Highmark Health Options Member Services at 1-844-325-6251 / TTY 711 or 1-800-232-5460.

1. Please include as much information as possible about your appeal request, including the type of service or item you want to appeal. Also, state if you would like to continue receiving services during the appeal process (see your member handbook for the rules on continuing services during the appeals process). **You have 60 days from the date on your Notice of Action to file your appeal.**

<<Issue>>.

Please turn to 2nd page for a few more questions

2. Is this about a service that has been denied by Highmark Health Options?
   Yes ☐ No ☐ Does not apply ☐

3. If you do not receive this service, is your life or health in immediate danger?
   Yes ☐ No ☐ Does not apply ☐

4. Are you already receiving these services?
   Yes ☐ No ☐ Does not apply ☐

5. What outcome do you want to happen as a result of your appeal?

Your Rights:

1. You have the right to submit evidence or allegations of fact or law, in person or in writing.

2. You or your representative have the right to review any information related to your appeal, free of charge.

3. You have the right to have a Highmark Health Options staff member assist you in the appeal process.

4. If you are a member representative or a provider filing on behalf of a member, you must obtain the member's written consent.

These Rights have been explained by: Date:

Member or Guardian signature Date

Relationship to above

This form must be signed by the member or the member's guardian <u>and</u> returned within 30 days of the date on this form to start the appeal.