

Non-Medicare Member Appeal Request Form

Please use this form to submit your appeal in writing. You may attach additional sheets, if necessary. If you have filed a standard appeal verbally, you must send this form back to the Plan prior to our completion time frame of your verbal request. If the form or written request is not received, no decision will be returned to you.

Medicaid

Request Date: _____

Has the service been provided yet? Yes No

Expedited Request: Yes No * See Below

Requestor (Appellant) Information

Name: _____

Address: _____

City: _____

Telephone: _____

Contact Person: _____

Relationship to Member:

- Self Appointed Representative Power of Attorney Parent/Guardian
 Provider (must have written consent from member to file on member's behalf)

Member Information

Name: _____

Address: _____

City: _____

ID Number: _____

Date of Birth: _____

Telephone: _____

SERVICES PLANNED INFORMATION (Pre-service Request)

Who are you requesting to provide the service?

Name: _____

Address: _____

City: _____

Telephone: _____

Contact Person: _____

What date is the service planned to begin? _____

Why do you feel the planned service should be authorized?

If your denial received was for a request for an out-of-network provider, why do you feel we should authorize the request?

SERVICES PROVIDED INFORMATION (Retrospective request)

Who provided the service(s) or who are you being billed by?

Name: _____

Address: _____

City: _____

Telephone: _____

Contact Person: _____

Date(s) of Service: _____

Please state why the services were not authorized prior to services being rendered:

I hereby request an appeal described in this document and understand that in order for the appeal to be considered, Harmony Health Plan (the Health Plan), may need medical records and other records or other information related to my appeal. I authorize persons or entities that have any medical or other records, or knowledge of me or my dependants, to release such information to Harmony Health Plan (the Health Plan). Those persons or entities may include any: 1) licensed physician; 2) medical practitioner; 3) hospital, 4) clinic or other medical or medically-related provider; 5) insurer; 6) employer; or 7) other organization, institution, or person. I specifically authorize the release of the following records or information if needed for the review of my appeal: any and all medical records and information about, associated with, or with reference to: 1) a positive test result for HIV infection; 2) ARC; 3) AIDS; 4) alcohol or drug dependency; and 5) mental and nervous disorders.

Member or Authorized Representative's Signature

Date

You may fax to (866) 201-0657 or mail to:

Harmony Health Plan
Attn: Appeals Department
P.O. Box 31368
Tampa, Florida 33631-3368

If you have any further questions or concerns regarding this form, or about your appeal and grievance rights, please contact Customer Service at (800) 608-8158, or you may also access TTY/TDD (877) 247-6272, if hearing impaired. Our hours of operation are Monday - Friday 7:00 a.m. – 7:00 p.m. ET, except for holidays.

*** Expedited Appeal:**

An appeal for a service that has not already been rendered and which taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

- **A request for expedited appeal submitted by your treating physician or with support from your treating physician will automatically be processed as an expedited appeal.**
- **If either of these are lacking, the Plan will review your request and determine if your request should be processed as expedited. If we do not agree with your request, we will notify you and provide you with grievance rights to grieve our decision not to expedite your grievance. Your request will then be transferred to the Standard Appeal process and a decision will be issued within 15 business days.**

Appeal Timeframes

Standard request: 15 business days from receipt

Expedited request: 72 hours from receipt