MEMBER/APPLICANT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL): _____ ***DATE:*** _____

ADDRESS: _____ ***CITY:*** _____ ***STATE:*** _____

ZIP CODE: _____ ***PHONE:*** _____ ***DATE OF BIRTH:*** _____

NAME OF INDIVIDUAL FILING FORM (IF DIFFERENT FROM ABOVE)

NAME (LAST, FIRST, MIDDLE INITIAL): _____ ***DATE:*** _____

ADDRESS: _____ ***CITY:*** _____ ***STATE:*** _____

ZIP CODE: _____ ***PHONE:*** _____

DESCRIPTION OF APPEAL OR GRIEVANCE: (Please include dates, names, locations, also any other attempts to resolve the problem, attaching additional pages as necessary.)

WHAT SOLUTION DO YOU WANT?

CONTINUATION OF SERVICES

For members with a Serious Mental Illness, your services under appeal will be continued during the appeal process, unless doing so poses a serious threat of harm to you or others.
For appeals relating to Title XIX or XXI services, please check *one* of the following:

☐ I am requesting that the services I am appealing be continued during the appeal process. I understand that if I lose my appeal, I may be required to pay for the cost of the services that were continued during the appeal process.

☐ I do not want the services I am appealing to be continued during the appeal process.

MEMBER/APPLICANT SIGNATURE: _____ **DATE:** _____

If form is filled out by an individual other than the member, fill out the below information.

RELATIONSHIP TO THE MEMBER/APPLICANT*:*
(i.e. Provider, Health Care Decision Maker, Designated Representative)

PROVIDER, HEALTH CARE DECISION MAKER, DESIGNATED REPRESENTATIVE SIGNATURE: _____ **DATE:** _____