Wellpoint | Hawki Iowa HHS

Request for Appeal Form

To ask for an appeal, please fill out and mail us this form. It will help us understand your request. We will send you a letter within three business days to let you know we received the form. We will send you a letter within 30 calendar days after we get the form to let you know what we decide.

Member name: _____

Parent's or guardian's name (if service is for a child): _____

Wellpoint Iowa ID#: _____

Reference Number: _____

Name of provider who wants to give or who gave you the service: _____

_____

Provider office address: _____

_____

Provider office phone number(s): _____ / _____

Type of service you want: _____

_____

Why you want the service: _____

_____

Have you received the service? ☐ Yes ☐ No

Type of service you received: _____

Why you received the service: _____

Date you had or want to have the service: _____

Why you are asking for an appeal: _____

_____

_____

Sign and send this form to:
Member Grievances and Appeals
Wellpoint Iowa, Inc.
4800 Westown Parkway, Ste. 200
West Des Moines, IA 50266

Signature: _____ **Date:** _____
Member, parent, legal guardian or authorized representative*

*An authorized representative must be named by the member, parent or legal guardian. The provider may act on behalf of the member with the member's/responsible party's written consent. An authorized representative cannot make healthcare decisions that involve the financial duty of the member, parent or legal guardian unless the member gives his or her OK in writing.

If you need help, please call Member Services toll free at 833-731-2140 (TTY 711), Monday through Friday, 7:30 a.m. to 6 p.m. Central time, except holidays.

Enclosures: Get help in another language
Nondiscrimination notice