



Appeal consent form

If you have any questions, please call Member Services at 833-707-0867. Usted puede obtener ayuda de la lengua llamando Servicios del Miembro en 833-707-0867.

This form will help Wellpoint Maryland, Inc. look at your appeal. Please fill out the whole form. If you need help with the form, please call Member Services at **833-707-0867 (TTY 711)**, Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

Member name: _____

Member ID #: _____

Parent or legal guardian's name (if the service is for your child):

Name of doctor who asked for or gave the service:

Name of hospital where you are admitted or are requesting admission:

Type of services you want or received: _____

Why you want or received the service: _____

Date you had or would like to have the service: _____

Why would you like us to look at your case again? _____

If you want someone else to help you with your appeal or to handle your appeal for you, write the person's name here:

Please send us this form and any medical information you have about this service to the address below. You can also send any information you feel we need to look at for your case. Send this form to:

Central Appeals Processing
Wellpoint Maryland, Inc.
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax: 844-887-6353

By signing this form, you are giving Wellpoint the right to get any of your medical records we need to look at for your case.

Your signature: _____ Date: _____

Services provided by Wellpoint Maryland, Inc.