



MEDICAL APPEAL FORM

Please fill out this form. You do not have to send the form to us but it will help Wellpoint look at your appeal. Please fill out the whole form. You can also call us to ask for an appeal or if you need help with this form. Call Member Services at 833-731-2160. We will process your appeal request made by telephone even if you do not send this form.

We will send you a letter within 30 days of when we get your appeal request. The letter will let you know what we decide.

RE: Member Name: _____

Member ID Number: _____

CHIP ID Number: _____

Parent or Guardian's Name
(If the service is for your child): _____

Reference or Authorization Number from denial letter: _____

Type of services you want or received: _____

Why you want or receive the service: _____

Date you had or want to receive the service: _____

Why are you appealing: _____

You can send us this form and any other information you feel we need to look at for your appeal to the address below.

I authorize _____ to appeal on my/my child's behalf.

Send this form to:

**Health Care Management Services/Appeals
Wellpoint
2505 N Hwy 360, Suite 300
Grand Prairie, TX 75050**

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

Your Signature: _____
(Member or Parent/Guardian of child)

Date: _____