Wellpoint

Member Appeal Request Form

If you got a Notice of Action letter from Wellpoint West Virginia, Inc. and disagree with the action we took, you may complete this form to ask for an appeal. Remember, you must ask for an appeal within 60 calendar days from the date on the Notice of Action letter. You may ask for an appeal by filling out this form and sending it to us.

Mail to: Attn: Grievance Department
Wellpoint West Virginia, Inc.
200 Association Drive, Ste. 200
Charleston, WV 25311
Fax to: 877-833-5729

You may also ask for an appeal by sending a letter to the address above or faxing a letter to the fax number above. We will write and tell you what we decide within 30 calendar days from the date we get your appeal.

Instructions: Please fill out the form completely and attach any paperwork you want us to review.

Section 1: Member Information			
Last name	First name	M.I.	Date of birth
Phone no.	Medicaid ID no.	Email address (optional)	
Street address	City	State	ZIP
I am asking for an expedited (fast) appeal. ☐ Yes ☐ No			

Section 2: Appeal Information
I am filing this appeal because Wellpoint: ☐ Will not pay for a medical service I received. ☐ Will not say it's OK for me to get a medical service. ☐ Stopped paying for a medical service I was receiving. ☐ Took too long to decide if it would pay for a medical service.

Signature	Date
X	

Please complete both sides of this form.

Section 3: Representative Information				
I have a representative who is helping me file this appeal. ☐Yes ☐No **Note:** A representative is **not** required.				
Last name	First name	M.I.	Phone no.	
Street address	City		State	ZIP
You may choose anyone you wish to help you file an appeal, including an attorney or a doctor. If you complete the block on the previous page telling us someone is helping you file the appeal, we will send you an Appeal Representative Form. You must sign the Appeal Representative Form and return it to us before we can act on your appeal.				

SECTION 4: Additional Information

Please provide below any additional information you feel may be helpful with your appeal request. Tell us why you are appealing and why you disagree with our decision. Please provide us with the names of any providers who may have records about the service in question. This information becomes part of the permanent record. Please write clearly. Use extra paper if needed.

If you need help with this form, please call our Customer Care Center at 800-782-0095 (TTY 711). We're here to help Monday through Friday from 8 a.m. to 6 p.m. Eastern time.