Health Plan of San Joaquin

Member Appeal Form

Member Name:_____
Last First Middle Initial

Member Address: _____ Phone:_____

City: _____ State: _____ Zip Code: _____

Member ID#: _____ Birthdate: _____ Sex: _____

Doctor's Name:_____

Appeal

What do you want to appeal? (List item/service/med that is denied/deferred/modified) __

_____

When was this denied? (List date denied. This can be the date on your NOA letter)_____

_____

Why is this being appealed? (List why this is medically necessary for you)_____

_____

Please list any records are sending in with this form: (Such as: a copy of your doctor's notes or an x-ray)_____

_____

_____

Have you tried any other things (Meds/Treatments)? Yes ☐ No ☐ If you said "yes", please explain: _____

_____

_____

Will you need language help? Yes ☐ No ☐ Language:_____

Your Rights:

Health Plan of San Joaquin will send me an appeal resolution within 30 days of getting this appeal.

My cooperation is voluntary.

I have the right to disenrollment.

I have the right to contact the Department of Managed Health Care.

I have the right to a State Fair Hearing (Medi-Cal members only).

_____ _____

Signature Date

I allow Health Plan of San Joaquin to get: medical records; claims records; or other records. These records will be used for my appeal.

_____ _____

Signature Date

Do you want your doctor to file an appeal for you? Yes ☐ No ☐ If you answered "Yes": I Allow my doctor_____(List Doctor's name) to file an appeal on my behalf.

_____ _____

Signature Date

Did someone help you fill out this form? Yes ☐ No ☐ If you answered "Yes":

Name: _____ Relationship: _____

Address: _____ Telephone: _____

_____ _____

Signature Date