Health Plan of San Joaquin

Mountain Valley Health Plan

Member Appeal Form

Member Name _____

Last

_____ _____

First Middle Initial

Member Address _____

City _____ State _____

Zip Code_____ Phone _____

Member ID# _____

Birth Date _____ Sex _____

Primary Care Provider Name _____

Appeal

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

Health Plan of San Joaquin | Mountain Valley Health Plan

Member Appeal Form

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 you are sending with this form (such as a copy of your doctor's notes or an X-ray):

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Have you tried any other things (meds/treatments)? ☐ Yes ☐ No

If you said “yes,” please explain:

Will you require language assistance? ☐ Yes ☐ No

Language: _____

Your Rights

Health Plan of San Joaquin/Mountain Valley Health Plan (“Health Plan”) 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 _____

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I allow Health Plan to get: Medical records; claim 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 complete this form? ☐ Yes ☐ No

If you answered "Yes":

Name _____

Relationship _____

Address _____

City _____ State _____

Zip Code_____ Phone _____

Signature _____ Date _____