SimpraAdvantage
Alabama's Healthplan

Member Appeal Form

Member Information

Full Name (Last, MI, First): _____

Mailing Address: _____

City:_____State:_____ ZIP: _____

Member's ID (see ID Card): _____

Member's Phone Number: _____

Member's Email Address: _____

Provider Information

Name:_____

Address:_____

City:_____State:_____ ZIP: _____

Office Phone Number: _____

Office Fax Number: _____

Office Contact Person: _____

If Requestor is other than the Enrollee or Provider, please provide contact information

Requestor's Full Name (Last, MI, First): _____

Requestor's Relationship to Enrollee: _____

Requestor's Mailing Address: _____

City:_____State:_____ ZIP: _____

Requestor's Phone Number: _____

Requestor's Email Address: _____

Note on Representatives

You or your provider may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative and documentation demonstrating their authority to represent you must be submitted.

A completed* Authorization of Representation Form CMS-1696 *or a written equivalent should be attached if it was not submitted at the coverage determination level.

For more information on appointing a representative, contact your plan or 1-800-MEDICARE.

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Service Request

Denied Service / Item: _____

Did you receive a denial letter? ☐ Yes ☐ No

If yes, when (MM/DD/YYYY)? _____

Expedited Decision

If you or your physician believes that waiting 30 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician indicates that waiting 30 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your physician's support for an expedited appeal, we will decide if your case requires a fast decision.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS**

If you have a supporting statement from your prescriber, attach it to this request.

Reason for Appeal

Please explain your reasons for appealing below. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your provider and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medical Coverage.

_____

_____

_____

_____

_____

_____

Requestor's Signature (Member, Provider, or Member representative) **Date**

If you have questions or need assistance with this form, please call our Member Services Department at 1-844-637-4770 (TTY 1-833-312-0044).

Mail this Form to:

Simpra Advantage
Attn: Appeals & Grievances
PO Box 20648
Tampa, FL 33631