ambetter. FROM arizona complete health

HEALTH CARE APPEAL REQUEST FORM

Insured Member's Name: 34T Member ID #: 34T
Name of representative pursuing appeal (if different from above):
34T
Mailing Address: 34T Phone #: 34T
City: 34T State: 34T Zip Code: 34T

Type of Denial:☐ Denied Claim (Service Received) ☐ Denied Service (Not Yet Received)

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health?

☐ Yes ☐ No

If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing (what do you want paid or authorized)?
34T

Explain why you think AzCH should pay or authorize this service (attach additional pages if needed):
34T

**Make sure so attach everything that shows why you believe AzCH should pay for, or authorize the requested service including any medical records, letters from your doctor(s), notes, brochures, etc. If you are requesting an expedited appeal you MUST include the treating provider certification (a form is available on our website).*

Signature of insured or authorized representative _____ Date _____

[Form ID]