# Member Appeal Request Instructions

**An appeal is a request to change a previous adverse decision made by Alliant Health Plans. You or your authorized representative (including a health care provider) may appeal the adverse decision related to your coverage.**

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**Step 1:** Contact Alliant's Customer Service department at 800-811-4793 to review any adverse coverage determinations and/or payment reductions. We may be able to resolve your issue outside of the formal appeal process. If a Customer Service Representative cannot resolve the initial coverage decision, they will advise you of your right to request an appeal.

**Step 2:** Complete and mail this form and/or appeal letter along with any supporting documentation to the address at the bottom of the Member Appeal Form. By providing complete and accurate information, we can perform a timely and thorough review. If assistance is needed in preparing your appeal, you can contact Customer Service. Your appeal should be submitted within 180 calendar days from the date of the initial Explanation of Benefits (EOB). You will receive a decision in writing.

**Step 3:** If anyone other than the patient is completing form, please include complete Protected Health Information (PHI) form. Following is a link to obtain a copy of the PHI form.
alliantplans.com/wp-content/uploads/Authorization-to-Share-PHI-updated-10-2015.pdf

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**REQUEST FOR AN APPEAL SHOULD INCLUDE:**

1. A copy of the First Level Appeal decision letter, if applicable.
2. Any documentation supporting your appeal; including but not limited to bills and any applicable proof of payment to provider. For adverse decisions based upon lack of medical necessity, additional documentation may include a letter from your provider describing the service or treatment and any applicable medical records.

If you submit a letter in place of the Member Appeal Form, please specify in your letter this is a **Member Appeal**. Please include all the information requested on the Member Appeal Form.

# MEMBER APPEAL FORM

**DATE REQUESTED:** MM/DD/YYYY

## SUBSCRIBER INFORMATION

| Subscriber Name: | | Subscriber ID Number: |
|---|---|---|
| Patient Name: (As shown on ID card) | | Date of Birth: MM/DD/YYYY |
| Subscriber Phone Number: | Subscriber Email: | Subscriber Address: |

If anyone other than patient is completing form, please supply, name, relationship, phone #, email, and address. Please include completed PHI form. alliantplans.com/wp-content/uploads/Authorization-to-Share-PHI-updated-10-2015.pdf

## PROVIDER INFORMATION

Provider/Group Name:

Service Location:

## APPEAL INFORMATION

Type of Appeal *(Check one)*: ☐ First Level Appeal ☐ Second Level Appeal

| Claim Number: | Date of Service: MM/DD/YYYY | Amount Billed: $ |
|---|---|---|

Explain reason for appeal request (If space is insufficient, please attach additional documents):

***Note: Supporting documentation is required for Appeal Review.*** *(See instructions)*

## IMPORTANT INFORMATION

- First Level appeals must be submitted within 180 days from the date of the EOB.
- Second Level appeals must be submitted within 60 days from date of First Level Appeal decision letter.

**To file claim appeals, please submit this form and supporting documentation to one of the following:**

**Mail**: Alliant Health Plans, Inc.
Appeals Department
P.O. Box 3708
Corpus Christi, TX 78463

**Fax**: 1 (866) 634-8917

**To file medical appeals (including when a service has not been rendered, i.e., UM appeals), please submit this form and supporting documentation to one of the following:**

**Mail**: Alliant Health Plans, Inc.
UM Appeals Department
9601 Amberglen Blvd. Ste. 225
Austin, TX 78729

**Fax**: 1 (866) 370-5667

Note: This form is intended for internal reviews only. For information regarding external appeals, please refer to your Certificate of Coverage or contact Customer Service at (800) 811-4793.

## Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans ]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

જો તમે અથવા તમે કોઇને મદદ કરી રહ્ાાં તેમ ાંથી કોઇને [એસબીએમ ક ર્યક્રમન ાં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દભ વષર્ો િ ત કરિ મ ટે,આ [અહીં દ ખલ કરો નાંબર ] પર કોલ કરો(800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ወይም እርስዎ የሚያግዙትግለሰብ፣ ስለAlliant Health Plansጥያቄ ካላችሁ፣ ያለ ምንም ክፍያበቋ ንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣(800) 811-4793 ይደውሉ።

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधकिार है। ककसी ‍िभाषषए से बात करने के लिए, (800) 811-4793 पर कॉिकरें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Alliant Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر شما، يا کسی که شما به او کمک ميکنيد ، سوال در مورد Alliant Health Plans، داشته باشيد حق اين را داريد که کمک و اطلاعات به زبان خود را به طور رايگان دريافت نماييد (800) 811-4793. تماس حاصل نماييد

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がござ いましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

## Non-Discrimination

Alliant Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

## TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).