



## 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 (866) 403-2785 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 may 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 the form, please include a completed Protected Health Information (PHI) form. Follow the link to obtain a copy of the PHI form.

[alliantplans.com/wp-content/uploads/Authorization-to-Share-PHI.pdf](http://alliantplans.com/wp-content/uploads/Authorization-to-Share-PHI.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. <a href="http://alliantplans.com/wp-content/uploads/Authorization-to-Share-PHI.pdf">alliantplans.com/wp-content/uploads/Authorization-to-Share-PHI.pdf</a>		

PROVIDER INFORMATION
Provider/Group Name:
Service Location:

APPEAL INFORMATION		
Type (Check one): <input type="checkbox"/> Medical <input type="checkbox"/> Claim		
Appeal Level (Check one): <input type="checkbox"/> First Level Appeal <input type="checkbox"/> 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): _____ _____ _____ _____		
<b>Note: Supporting documentation is required for Appeal Review. (See instructions)</b>		

IMPORTANT INFORMATION
<ul style="list-style-type: none"> <li>• First Level appeals must be submitted within 180 days from the date of the EOB.</li> <li>• Second Level appeals must be submitted within 60 days from date of First Level Appeal decision letter.</li> </ul>

**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 1247  
Dalton, GA 30722

**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.  
Appeals Department  
P.O. Box 1247  
Dalton, GA 30722

**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 (866) 403-2785.