

APPEAL REQUEST FORM

Please complete this form and return it to us. Make sure that you have signed and dated the form. For help with this form, please call Customer Service, Monday – Friday, 8 a.m. to 8 p.m.:

- In Corvallis at 541-768-4550
- Toll-free at 1-800-832-4580
- TTY users should call 1-800-735-2900

For Internal Use Only:

1. WHICH HEALTH PLAN DO YOU HAVE? (Check one box):		
<input type="checkbox"/> IHN-CCO	<input type="checkbox"/> Samaritan Choice	<input type="checkbox"/> Samaritan Employer Group Plans
2. MEMBER INFORMATION		
This should be the person whose name is on the denial letter, bill, or explanation of benefits (EOB):		
First name:	Last name:	
Address:		
City:	State:	Zip:
Member ID#:	Phone:	
3. WHAT DECISION DO YOU WANT US TO CHANGE?		
Note: You may attach papers to this form to help explain your request. For example, you may want to include:		
<ul style="list-style-type: none">• A letter from your doctor or a copy of your medical records• Bills or explanation of benefits (EOB) that you have received• The denial letter		
TURN PAGE OVER TO FINISH THE FORM ►►►		

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4. WHY DO YOU THINK WE SHOULD CHANGE THE DECISION? Please use a blank page if you need more space.

5. IMPORTANT NOTICE FOR IHN-CCO MEMBERS:

If you are already receiving the service we denied, you can continue to receive the service if you send us this form within 10 days of the date on your denial letter. You may have to pay for the service you are receiving if we deny your appeal.

Check this box if you want to continue to receive the service we denied.

6. YOU CAN ASK US TO MAKE A FAST (EXPEDITED) DECISION ON YOUR APPEAL.

You can ask us to decide faster than usual if:

1. You think your health or mental health may be in serious danger, or
2. Your doctor says that waiting the usual amount of time for us to decide would put your life in serious danger, or
3. Your doctor says you have pain that cannot be controlled.

Check this box if you want a fast decision on your appeal.

7. SIGN AND DATE THIS FORM. If you have not signed and dated this form, we will not process your request.

If this request is for a child who is 18 or younger, their parent or legal guardian must sign:

Signature: _____ Today's date: _____
(mm/dd/yy)

Relationship to Member:

- Self
- Provider appealing for member (you must have written permission from the member to appeal)
- Authorized Representative (example: friend or relative of member)

You can choose to fax the form, mail or bring it to us in person.

- Fax: 541-768-9765
- Mail to: Samaritan Health Plans Operations – Appeal Team, P.O. Box 1310, Corvallis, OR 97339
- Visit us at: 2300 NW Walnut Blvd, Corvallis, OR 97330

IMPORTANT: Keep copies of this form and all other papers that have to do with this request.