



Member Appeal Submission Form

Mail, fax or email to:
Health Advantage
Member Response Coordinator
P.O. Box 8069
Little Rock, AR 72203
Fax: 501-212-8518
appeals@healthadvantage-hmo.com

To be considered a valid appeal, the Member Response Coordinator must receive it within 180 days of the final adverse decision of the plan.

Please note that the Health Advantage Appeals Department will not review the following items as appeals:

- Claims that have denied for records not received

Submitter's Information

Name: _____ Member ID# or Provider #: _____

Member's Contract Information

Name: _____
ID #: _____
Address: _____
City/State/Zip: _____
Telephone #: _____

Patient Information

Name: _____ Date of Service: _____

Name of Physician, Hospital or Other: _____

Please check one or more of the following reasons for the appeal:

- Disagree with the amount paid on a claim or with the amount of member copay/coinsurance
- Urgent or emergency claim denial
- Services denied as not medically necessary/ does not meet criteria
- Services denied as a pre-existing condition (please provide any previous insurance information)
- Claim denied for not obtaining a prior authorization
- Request a retroactive out-of-network referral
- Eligibility or other issue.

Please explain **(Please feel free to attach any medical records or a narrative explaining your appeal)**:

Providers: Did the member sign a valid specific waiver for the denied procedure? Yes _____ No _____
If a valid waiver was signed, please attach with the appeal request.

Please note that the Member Response Coordinator has 7 days from the date that the appeal is received to send a letter acknowledging receipt of an appeal. For most appeals notification of a decision will be sent within 30 calendar days for member appeals.