HIGHMARK HEALTH OPTIONS

Appeal Form

As a Highmark Health Options member, you can submit an appeal. An appeal is a request for a review of a denied or limited health care service. This includes the:

- Type or level of service.
- Reduction, suspension, or termination of a service.
- Failure to provide a service in a timely manner.
- Highmark Health Options' denial to pay all or part of a service.

Find more information in a letter called "Notice of Adverse Benefit Determination" that was mailed to you.

Use this form to file an appeal.

Please complete as much of the form as you can. Here is what you need to provide:

Member information: Find this on your member ID card.

Patient information: Provide information about the person the request is for. If this person is the same as the member, leave this section blank.

Service information: Tell us about the service, claim, or item related to your appeal. Find this information in letters from Highmark Health Options.

Reason for appeal: Tell us about your appeal. Use extra paper if necessary. Include the names of any staff or doctors involved, type of service, and service dates.

Print first and last name: Print the name of the person listed in the Patient Information section if that person is 18 or older or print the name of the parent or guardian.

Signature: The person listed in the Patient Information section should sign if that person is 18 or older. If that person is under age 18, the parent or guardian should sign.

Choose an authorized representative: You can choose to have an authorized representative help you with your appeal. To appoint an authorized representative, complete the Member Representation Consent Form.

How to submit this form: Use the enclosed reply envelope to return this form and any documents that will help us look into your complaint. If you do not have a reply envelope, send to:

Highmark Health Options West Virginia
Attn: Appeals and Grievances
614 Market Street
Parkersburg, WV 26101
Fax: 1-833-547-2022

What happens next: We will send you a letter to let you know we received your form. We will review the form and all supporting documents you have sent to us.

Need help? Call Member Services at 1-833-957-0020 (TTY: 711) or read about the grievance and appeal process in your Member Handbook.

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Member Information

Today's Date	Member ID Number	Date of Birth
First Name	**Last Name**	**Primary Phone Number**
Street Address		
City, State, ZIP		

Patient Information If same as above, leave blank.

First Name	Last Name	Date of Birth

Service Information

Provider Name	Date(s) of Service(s)
Provider Address	**Provider Phone**

Is this appeal about a service that has been denied by Highmark Health Options?

Yes ☐ No ☐ Does not apply ☐

Is your life or health in immediate danger if you do not receive this service?

Yes ☐ No ☐ Does not apply ☐

Are you already receiving these services?

Yes ☐ No ☐ Does not apply ☐

Would you like to continue receiving services during the appeal process?

Yes ☐ No ☐ Does not apply ☐

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

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Explain the Details of Your Appeal If more space is needed, use additional paper.

What do you want to happen as a result of your appeal?

Understanding Your Rights

1. You have the right to submit evidence or allegations of fact or law, in person or in writing.
2. You or your authorized representative have the right to review any information related to your appeal, free of charge.
3. You have the right to have a Highmark Health Options staff member assist you in the appeal process.
4. If you are a member's authorized representative or a provider filing on behalf of a member, you must obtain the member's written consent.

Print First and Last Name	Signature

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