COMMUNITY Health Options®

Member Appeal Form

Instructions

- This form is for use by Members enrolled in a fully insured plan from Community Health Options and Members enrolled in a self-insured employer plan. If you are a Member of a self-insured employer plan, please also fill out the Authorization for Disclosure of Protected Health Information form.
- This form is only used for requesting a formal appeal of any adverse determination.
- To appeal a pharmacy determination, please contact the phone number on the back of your insurance card for more information.
- Please fill in as many of the fields on this form that you are able, attach supporting documentation and submit everything via secure email, postal mail, or fax.
- Please allow up to 30 calendar days from the date your appeal is received for Community Health Options to process your appeal.

Member Information

First Name	M.I.	Last Name		Date of Birth
Member ID #	Claim #	Date of Service	Billed Amount	Authorization #

Physician/Healthcare Professional Information

Physician, Provider, or Practice Name		Contact Person	Amount Owed (Optional)
Practice Address	City	State	Zip Code

Please select the issue that best describes your appeal. The initial decision was related to:

- ☐ Claim processing
- ☐ Out-of-pocket, deductible, coinsurance amounts
- ☐ Medical necessity
- ☐ Other: _____

State the reason for the appeal and expected outcome below and attach supporting documentation.

Has anyone at Community Health Options tried to resolve the situation? If yes, please explain and provide the reference number(s) associated with the contact or call.

Requester Information	
Name of Requester	Relationship to Member
Phone	Email
Return Address (for notice regarding this request)	
Signature	Date

Email, mail, or fax this completed form along with all supporting documentation to:

Email: appeals@HealthOptions.org - Please utilize a secure email method only, to protect your private information. Check with your email provider if you are unsure if your email is considered secure.

Fax: (877) 314-5693

Mail: ATTN: Appeals
Community Health Options
Mail Stop 800
P.O. Box 1121
Lewiston, ME 04243 - 1121