PO Box 182273
Chattanooga, TN 37422
(866) 449-6849

Health Plan Appeal Request Form

To ask for a health plan appeal, you can call us at (866) 449-6849, Monday through Friday, 8 a.m. – 6 p.m., Central Time, email us at TXMemberInquiryResearchAndResolution@MolinaHealthCare.Com, or you can fill out this form and mail or fax it to us at:

Mail: Molina Healthcare of Texas
PO Box 182273
Chattanooga, TN 37422
Attn: Appeals and Grievances Department
Fax: (877) 816-6416

You must request an appeal by <date 60 Days from the date this notice is mailed>.

If you want to continue your services during your appeal, you must make your request by **<date must be the later of the following: date 10 Days from the date this notice is mailed, or the date services will change>**.

Mark the appeal you want:

Only select one.

☐ Health Plan Appeal
☐ Emergency Health Plan Appeal*

*Emergency health plan appeals should only be requested if you believe your health will be seriously harmed by waiting for your health plan appeal decision.

Denial Reference Number: [reference number]

Do you want your services to continue? ☐ Yes ☐ No

You must request for your services to continue by **<date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>**.

You can make this request by phone. Call us at (866) 449-6849 if you think this form will not reach us by mail before the deadline.

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Your Personal Information*

Member name:	Parent or authorized representative:
Member Medicaid ID and subscriber number:	Preferred phone number:

*If any of your contact information has changed, call the enrollment broker at 800-964-2777 or Molina at (866) 449-6849.

Your Authorized Representative's or Parent's Information

You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Reason for the Appeal

This section is optional. You can fill it out to tell us about your services under appeal and why you think they're needed.

Service under appeal:
Why you need them:

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Sign this form:
By signing this form, you or your authorized representative are requesting an appeal and giving your health plan, Molina, authorization to get your medical records and to contact your appeal representative if you listed one.

_____
Member/Authorized representative signature

_____
Printed name

_____
Date