Molina Healthcare of Iowa Medical Appeal Request

If you want to appeal the decision we have made, you may fill out the form or call us within sixty (60) calendar days of the date on the Notice of Adverse Benefit Determination.

If your health care provider thinks your life or health is in immediate danger because of the decision in the Notice of Adverse Benefit Determination, he/she can ask for an expedited appeal by either calling us or sending us this form.

If you want help completing this form, please call 844-236-0894.

Is the member or a health care provider requesting this appeal? ☐ Member ☐ Health Care Provider

Date: _____ Member ID#: _____

Member last name:_____

Member first name:_____ Member middle initial: _____

Current Address:_____ Apt. if app:_____

City:_____State:_____Zip:_____

Phone number:_____

Doctor's Name:_____

What kind of an appeal is this? Please check one:

☐ **Standard**

☐ **Expedited** - If your provider thinks your life or health is in immediate danger, you may ask for an expedited (quick) appeal decision.

☐ **Continuation of Benefits** - <u>You can only ask that you keep getting services</u> if Molina has terminated, suspended, or reduced a service that Molina had previously authorized. You must request continuation of those services within ten (10) calendar days of this Notice of Action. It also means that you may have to pay Molina for these services if the appeal decision is to deny the services.

What results are you hoping for from this hearing? _____

_____

_____

Please attach any information that will help us understand your medical case and your appeal, and send to:

Appeals & Grievances
Molina Healthcare Inc.
PO Box 93010
Des Moines, IA 50393
Fax 833-832-1922

Please note that if you choose someone else to file the appeal, you must fill out the attached "Authorized Representative for Managed Care Appeals" form below.

IOWA Health and Human Services

Authorized Representative for Managed Care Appeals

Complete this form to appoint an individual, organization, or provider to act on your behalf during the appeals process. This form shall be completed by the Medicaid member or their parent, if the member is a minor. **The member and the authorized representative must both sign this form.** Legal documentation such as a court order establishing legal guardianship, or a power of attorney can be submitted instead to designate a representative.

Appellant Information

First and Last Name		Date of Birth
Case Number	Medicaid ID Number	Telephone Number
Parent's Name, if appellant is minor (under age 18)		
Provide Detailed Explanation of What is Being Appealed		

By signing this form, I understand:

- I authorize my Authorized Representative to act on my behalf during my appeal and to have access to all protected health information regarding my appeal and agree that this information may be disclosed to other persons in connection with this appeal.
- This authorization is at my request. I have the right to refuse to sign this form and that it is strictly voluntary.
- My signature does not waive my right to represent myself.
- My signature does not waive my financial obligation should the appeal be decided in the Department's favor.
- This authorization automatically expires at the end of the appeals process or if I revoke this permission in writing. I can revoke this authorization by sending a written request by mail or fax to: Department of Health and Human Services, Appeals Bureau, 321 E. 12th Street, 4th Floor, Des Moines, IA 50319, Fax: (515) 564-4044.

Signature of Appellant or Parent, if appellant is a minor	Date Signed

Appellant Representative Information

Authorized Representative First and Last Name		
Organization or Provider Business Name		
Representative Mailing Address		
City	State	ZIP Code
Representative Email Address		
Representative's Relationship to Appellant	Representative Telephone Number	

By signing this form, the Authorized Representative understands:

As a condition of serving as an authorized representative, I agree to abide by relevant state and federal laws concerning conflicts of interest and confidentiality of information.

IMPORTANT NOTE: This form is not valid for appellants who are mentally unable to sign. If the appellant is mentally unable to sign this form, the person acting on their behalf must submit legal proof of guardianship with the appeal.

Signature of Authorized Representative	Date Signed

For a Managed Care Level 1 appeal, please submit the form to your assigned managed care organization. For a State Fair Hearing, submit the form directly to the Department of Health and Human Services at the address below.

Wellpoint Iowa, Inc. Grievances and Appeals PO Box 62429 Virginia Beach, VA 23466-2429 FAX: (844) 400-3465	Iowa Total Care Grievances and Appeals Department 1080 Jordan Creek Pkwy, Ste 400S West Des Moines, IA 50266 FAX: (833) 809-3868	Molina Healthcare Appeals and Grievances PO Box 93010 Des Moines, IA 50393 FAX: (833) 832-1922
Delta Dental of Iowa Attn: DWP Appeals and Complaints PO Box 9040 Johnston, IA 50131-9040 FAX: (888) 264-0195	DentaQuest Attn: Complaints, Grievances & Appeals P.O. Box 8206 Des Moines, IA 50301 FAX: 262-387-3704 Email: cgateam1@dentaquest.com	Department of Health and Human Services Appeals Bureau 321 E. 12th Street 4th Floor Des Moines, IA 50319 FAX: (515) 564-4044 Email: appeals@hhs.iowa.gov