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.