

MEDICAL APPEAL REQUEST

If you want to appeal the decision we have made, you can write a letter or fill out this form and send it to us within 180 calendar days from the date on the Notice of Adverse Benefit Determination for a regular appeal. You can also call us within 180 calendar days from the date on the Notice of Adverse Benefit Determination. If you call us first, you must still send a letter or this form to us within 15 business days after you called us.

If you or your doctor thinks your life or health is in immediate danger because of the decision in the Notice of Adverse Benefit Determination letter, you or the doctor acting on your behalf can ask for an expedited (quick) appeal by calling us. If you call us to request a quick appeal, you do not need to send Molina this form.

If you want help in filling out this form, please call (833) 644-1623.

Who is requesting this appeal (check one)?

Member Healthcare Provider Date: _____

MEMBER INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MI: _____

Member Address: _____

City: _____ State: _____ Zip: _____

Member Phone #: _____ Member Email: _____

Reason for Appeal: _____

HEALTHCARE PROVIDER INFORMATION:

Doctor Name: _____

Doctor Address: _____

City: _____ State: _____ Zip: _____

Name of Contact at Doctor's office: _____

Doctor Phone #: _____ Doctor Fax #: _____

Reason for Appeal: _____

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

**Molina Healthcare of Illinois, Inc.
Attn: Member Appeals and Grievances
PO Box 182273
Chattanooga, TN 37422**

Toll Free Number: (833) 644-1623

Fax: 855-502-5128

Email: MHI.IL.Appeal@MolinaHealthCare.Com

Authorized Representative Permission Statement

If your health care provider or another individual is filing the grievance for you, you must give your written permission.

I, _____ (your name), give my permission
for _____ (designee) to file this Grievance Form on my
behalf.

Member Signature

Date

Check this box to have your appeal processed as expedited

******Note*** All requests for an expedited appeal MUST be accompanied by supporting documentation from the requesting provider, indicating the reason for the expedited request.***