Appeal Request Form

Name of Person Filing Appeal: __________________________________________________________

Patient: ___________________________________ Relationship: _______________________

Service you are appealing: ____________________________________________________________

Describe why you disagree with the decision (you may attach additional information, such as a physician’s letter, bills, medical records, or any other documents to support your claim).

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MAGR 08/2014
APPOINTMENT OF AUTHORIZED REPRESENTATIVE
(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize ________________________________ to pursue my appeal on my behalf.

_______________________________________________  _______________________
Signature of Patient (If 18 years or older)                Date

_______________________________________________  _______________________
Signature of Authorized Representative*                Date
*(Parent, Guardian, Conservator or Other – Please Specify)

Address of Authorized Representative: ____________________________

City: _______ ___________________________ State: _______ Zip: ____________

Phone # Daytime (____) __________________ Evening (____) __________________

Mail this form and a copy of your denial notice to:

GlobalHealth, Inc.
ATTN: Appeals
PO Box 2393
Oklahoma City, OK 73101-2393

Be sure to keep copies of this form, your denial notice, and all documents and correspondence related to this claim for your records.

Para los miembros que hablan español:
Si usted no entiende los contenidos de esta carta, por favor llame a Servicios para los Miembros al <<1-877-280-5600>> y alguien le ayudara.