PriorityHealth

Medicare Member Appeal Form

Use this form to file an appeal if you received written notice that we made a coverage decision that was not in your favor. Provide any information you feel will help us better understand your concern and why you want us to reverse our decision. For more information about the appeal process refer to your Evidence of Coverage or our website *prioritymedicare.com*.

Section 1: Member information

Member name	Member ID number (from your Priority Health ID card)		
Street address			
City	State	ZIP code	Phone number
Provider name	Date of service		

Section 2: Provide all details of why you believe we should reverse our initial decision

Section 3: Signature

If someone is submitting the appeal on the member's behalf, an Appointment of Representative form (Form CMS-1696) must be attached. Form CMS-1696 can be downloaded at ***priorityhealth.com*** or obtained by calling the Customer Service number on the back of your membership card.

Signature	Date

Based on the information you have provided, Priority Health Medicare will make every effort to resolve your appeal in a satisfactory and timely manner. The appeal process won't begin until Priority Health Medicare receives this form.

Please return to: Priority Health Medicare
Appeals Department, MS 1150 1231 East Beltline NE
Grand Rapids, MI 49525