Federal Employees Health Benefits (FEHB) member appeal request form

You have a right to an appeal if you believe you are entitled to a service or benefit that has been denied. You may appeal within 6 months from the date of the initial denial notification. *Incomplete appeal forms may cause a delay in your appeal.*

Who can complete this form?

You or an authorized representative may fill out this form. To appoint someone to represent you, you must complete, sign and submit a 'Appointment of Representative request form'. Unless revoked or specified, this status is valid for one year at most from the date the form is signed.

If you are under the age of 18, a parent or legal guardian is automatically appointed as your authorized representative until you are 18 years of age.

For matters involving substance abuse or behavioral health treatment, a parent or legal guardian can act on your behalf if you are a dependent who is 14 years of age or older.

What must be done to request an appeal?

To request an appeal, you **must** take the following action:

- Complete, sign and submit one appeal form for each member/appeal reason.
- Attach documentation relating to your appeal. This includes:
    - Explanation of Benefits (EOB), receipts, medical records, statements from providers, research material, etc. ***Always send copies. Never send original documents.***

Where do I send the completed form?

Return the completed form to Priority Health by:

Mail
Priority Health
Attn: Grievance & Appeals Department
1231 East Beltline NE, MS 1145
Grand Rapids, MI 49525

Email
phmemberappeals@priorityhealth.com

Fax
616.975.8894

How long does it take for a decision to be made?

If services **have not been** received, we will send you a written decision within 72 hours of receiving your request. If services **have been** received, we will send you a written decision within 30 days of receiving your request. If we request additional information, you or your provider must send the information within 60 days of your request.

For expedited reviews, we will send you a written decision within 72 hours of receiving your request.

How do I get an expedited review?

Expedited reviews are only available when the standard review time could put your life in danger or delay treatment for severe pain, which must be confirmed by a healthcare provider.

What if I have questions or it has been more than 6 months since I submitted an appeal?

You can contact our customer service team by calling the number on the back of your member ID card or logging into your member account at ***priorityhealth.com*** to send us a message.

1. Member information

First name	Last name	M.I.

Date of birth ____/____/____	Priority Health ID number

Street address	Unit/apt./lot no.

City	State	Zip Code

Email	Phone ( ) -

Are you out of state?

☐ Yes ☐ No

If 'Yes', what is the State? _____

Are you an authorized representative completing this form?

☐ Yes *(complete section 1a.)* ☐ No

1a. Authorized representative details*

First name	Last name	M.I.

What is your relationship to the member? *(choose one)*

☐ Conservator ☐ Dependent ☐ Healthcare provider ☐ Legal guardian ☐ Parent

☐ Power of attorney ☐ Spouse ☐ Other: _____

If 'Healthcare provider', provide your National Provider Identifier (NPI):

_____

Street address	Unit/apt./lot no.

City	State	Zip Code

Email	Phone ( ) -

Signature of member, parent (if under the age of 18) or legal guardian	Today's date ____/____/____

2. Decision information

Where do you want the decision to be sent? *(mark all that apply)*

☐ Member ☐ Authorized representative ☐ Other individual or place *(complete section 2a.)*

2a. Other individual or place details

Name

Street address	Unit/apt./lot no.

City	State	Zip Code
Email		Phone ( ) -

3. Appeal type

What is the type of issue you are appealing? *(choose one)*

☐ Deductible or copay ☐ Medical device ☐ Medical service ☐ Medication

☐ Non-covered services ☐ Payment denial or underpayment

☐ Preservice denial *(complete section 3a.)*

3a. Preservice details

Provider name	Authorization number
Location name	Date of service(s) ____/____/____

Type of service(s)

Have you already received the service(s)?

☐ Yes ☐ No

If 'Yes', what is the total charged amount? _____

If 'Yes', what is the claim number? *(you can add multiple claim numbers)*

_____

Would the standard review time put your life in danger or delay treatment for severe pain?
A healthcare provider will confirm this.

☐ Yes ☐ No

If 'Yes', explain:

4. Appeal details

Describe the reason you are requesting an appeal with a brief explanation of the problem and the resolution you are seeking. If applicable, please include details on the service you have requested or received, such as dates, provider names, claim numbers, authorization numbers, etc. You may attach additional pages if there is not enough room.

5. Acknowledgement

By submitting this appeal, I understand that Priority Health will complete an investigation of my appeal for review by the Appeal Committee. I understand that this may involve contacting appropriate providers to gather relevant medical records including photos, claims information relating to diagnosis, prognosis and treatment for physical and mental illness, mental health, substance abuse, communicable diseases, serious communicable diseases and infections and other conditions, ailments, sicknesses and diseases, including human immunodeficiency virus (HIV) infections and acquired immunodeficiency syndrome (AIDS).

Signature of member, parent (if under the age of 18) or legal guardian	Today's date _____/_____/_____

Priority Health must have an Appointment of Representative (AOR) form or other legal documentation (Durable Power of Attorney, Executor of Estate, etc.) when a request for a grievance and/or appeal is submitted by someone other than the member. If this form or other legal documentation is not on file, we are unable to continue with the appeal or grievance. You can download an AOR form at* ***priorityhealth.com**, complete it and include it with this request. Or you can include applicable legal documentation with this form. If you're unable to obtain the AOR form, Priority Health will request this information when your grievance and/or appeal is received if it is not included. If you have any questions, please contact us at the phone number on the back of your member ID card.*

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

Priority Health

We offer free language assistance services and auxiliary aids and services.

Albanian (Shqip) - VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-942-0954 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic (العربية) - تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-942-0954 (TTY:711) أو تحدث إلى مقدم الخدمة.

Assyrian (ܐܬܘܪܝܐ) - ܡܙܗܪܢܘܬܐ: ܐܢ ܐܢܬ ܡܡܠܠܬ ܐܬܘܪܝܐ، ܡܫܡܫܢܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ ܡܨܛܒܝܢ ܠܘܬܘܟ. ܐܦ ܡܫܡܫܢܘܬܐ ܕܗܝܪܬܐ ܕܚܕܪܝܐ ܕܐܬܝܐ ܒܝܕ ܓܘܢ ܐܦ ܐܝܬ ܐܬܝܐ ܡܓܢܐܝܬ. ܩܪܝ 1-800-942-0954 (TTY:711) ܡܡܠܠ ܥܡ ܡܫܡܫܢܐ ܕܝܠܘܟ.

Bengali (বাংলা) - মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-942-0954 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Chinese – Simplified (中文) - 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-942-0954（TTY：711）或咨询您的服务提供商。

Chinese – Traditional (中文) - 注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-942-0954 (TTY: 711) 或與您的提供者討論。

English - ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-942-0954 (TTY: 711) or speak to your provider.

French (Français) - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-942-0954 (TTY: 711) ou parlez à votre fournisseur.

German (Deutsch) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-942-0954 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Greek (Ελληνικά) - ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-942-0954 (TTY: 711) ή απευθυνθείτε στον πάροχό σας.

Gujarati (ગુજરાતી) - ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-942-0954 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Haitian Creole (Kreyòl Ayisyen) - ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-942-0954 (TTY: 711) oswa pale avèk founisè w la.

Hindi (हिंदी) - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-942-0954 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Hmong (Hmoob) - LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-942-0954 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Italian (Italiano) - ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-942-0954 (TTY: 711) o parla con il tuo fornitore.

Japanese (日本語) - 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-942-0954 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

Korean (한국어) - 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-942-0954 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laos (ລາວ) - ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-942-0954 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Polish (Polski) - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-942-0954 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Russian (Русский) - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-942-0954 (TTY:711) или обратитесь к своему поставщику услуг.

Serbian (Srbski) - PAŽNJA: Ako pricate srpski, besplatne jezicke uslugei su vam dostupne. Takođe, odgovarajuca pomocna sredstva i usluge za pružanje informacija u dostupnim formatima su takođe dostupni besplatno. Pozovite 1-800-942-0954 (TTY: 711) ili se obratite svom pružaocu usluga.

Spanish (Español) - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-942-0954 (TTY: 711) o hable con su proveedor.

Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-942-0954 (TTY: 711) o makipag-usap sa iyong provider.

Urdu (اردو) - توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں 1-800-942-0954 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Vietnamese (Việt) - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-942-0954 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Source: lep.gov and *cms.gov*
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