Medicare Member Appeal Form

Member information		
Last name	First name	M.I.
Date of birth / /	Priority Health subscriber ID	
Street address		Unit/apt/lot no.
City	State	Zip code
County	Phone	
Provider name	Date of service	

Why you believe we should reverse our initial decision

Signature

If you are 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	Today's date

A paper form can only be accepted with a handwritten signature. Electronic, digital or typed signatures are not permitted per the Centers for Medicare and Medicaid services.

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Instructions

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, please reference Chapter 9 of your Evidence of Coverage (EOC), which can be found in your member portal account at ***member.priorityhealth.com.***

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

How do I submit this completed form?

Mail:
Priority Health, MS 1150
1231 East Beltline NE
Grand Rapids, MI 49525

Have questions or need help?

You can contact Customer Service by calling us toll-free at 888.389.6648 (TTY users should call 711), from 8 a.m. to 8 p.m. seven days a week. You can also send a secure online message from your member portal account at ***member.priorityhealth.com*** by clicking on **Get help** in the top right corner of your screen. We'll reply within two business days.