MEMBER APPEAL FORM

COMMUNITY HEALTH CHOICE

You may ask for an appeal if:

- You disagree with Community Health Choice's answer or
- You believe we made a mistake in denial of your requested medical services

You or your authorized representative may use this form to submit your appeal. Or call Community Health Choice Member Services for assistance.

TODAY'S DATE: _____ **AUTHORIZATION REFERENCE #:** _____

MEMBER INFORMATION

Member ID Number	Member Name	Member Date of Birth

Address	City, State, ZIP

Phone Number	Alternate Phone Number (Optional)

Name of Authorized Representative	Phone Number of Authorized Representative

TYPE OF APPEAL

An **expedited appeal** is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

☐ **Standard Appeal** ☐ **Expedited Appeal** ☐ **IRO**

Briefly describe your appeal:

_____

_____

_____

_____

_____

Signature **Date**

Please send your form and any supporting documentation by mail or fax to:

Community Health Choice
Attention: Appeals Coordinator
4888 Loop Central Dr. Suite 600
Houston, Texas 77081
Fax: 713.295.7033 / Attn: Appeals Coordinator