

# Member Request to File an AHCCCS/ALTCS Appeal

## AHCCCS/ALTCS Member Information:

Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

## Information about Person Filing Appeal (if different from above):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to Member:  Parent  Guardian

Other \_\_\_\_\_

## Information about Appeal:

I am requesting an appeal of my health plan's decision to:

Date of Plan Decision: \_\_\_\_\_

- Deny or limit a request for a new service, including limiting type and scope of service
- Reduce, suspend, or terminate an existing / current service
- Failure to provide an approved service in a timely way
- Other \_\_\_\_\_

I am appealing this decision because: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Please use back of form or attach additional sheets if you need more room.)

## Continuation of Services During Appeal

I would like my services continued during the appeal:  Yes  No

\*\*To continue services, appeal must be (1) filed within 10 days of decision & (2) involve existing or current services

## Expedited Appeal

I am requesting an expedited appeal:  Yes  No

\*\*Health plan must expedite the appeal & issue a decision in 3 working days if it is determined that the time of a regular appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Recommended: provide supporting documentation from member's doctor about need for expedited appeal.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

AHCCCS/ALTCS Member  Guardian  Parent  Other \_\_\_\_\_

\*\*If form is signed by someone other than member or parent of child under 18, please attach your written authority to act on behalf of the member (i.e. Letters of Guardianship, Designation of Representative).

Appeal Filed with: Grievance and Appeals Coordinator

Health Plan: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Appeal Filed by:  Certified Mail or fax (NO. \_\_\_\_\_) (recommended)

US Mail  Hand Delivered

**Make sure to keep a copy of this completed form for your records!**