Medicare Member Appeal Form

PriorityHealth®

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.*

Member information			
Member name			Member ID number (from your Priority Health ID card)
Street address			
City	State	ZIP code	Phone ( )
Name of person filing appeal (if different from member)			Relationship to member

Provide all details of why you believe we should reverse our initial decision	
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.

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

The appeal process won't begin until Priority Health Medicare receives this form.

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