Priority Health Managed Benefits, Inc. Appeal form

PriorityHealth
THINK SMART. LIVE SMART.

Section 1: Member information

Member name	Contract number		
Address	City	State	ZIP
Home phone/Hours available	Work phone/Hours available		
Person asking for appeal	Relationship to member		
Name(s) of providers involved			

Section 2: Appointment of representative

Part 1: To be completed by the member

I appoint the following individual, _____, to act as my representative in requesting an appeal regarding the adverse determination outlined below. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeal information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that I must complete the enclosed Authorization for Release of Personal Health Information form to allow disclosure of my personal medical and behavioral health information to my authorized representative.

x _____
Member signature Date

Part 2: To be completed by the representative

I, _____, hereby accept the above appointment.

x _____
Representative signature Date

Representative address	Representative phone number

Section 3: Appeal information

1. Under what section of your Summary Plan Description or Schedule of Benefits do you believe this service would be covered?

2. What are the facts about this appeal?

continued >

3. What action are you asking Priority Health to take and why?

Section 4: Acknowledgment

By submitting this appeal, I understand that Priority Health will complete a thorough 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).

x _____

Signature (member, parent/legal guardian if member is under 18 years of age, or authorized representative) Date

Section 5: Confidentiality

Priority Health is committed to maintaining the confidentiality of the information that you send to us. The attached form must be completed and submitted with your appeal form if:

- You would like Priority Health to disclose any information regarding your appeal to someone other than yourself, such as your spouse, a family member, your authorized representative or any other third party.
- You are a parent submitting the appeal on behalf of your dependent child when the dependent child is 18 years of age or older.
- You are a parent submitting the appeal on behalf of your dependent child when the dependent child is 14 years of age or older and your appeal involves substance abuse or behavioral health treatment.

Return completed form to:
Priority Health Managed Benefits, Inc.
Appeal Coordinator, MS 1145
PO Box 269
Grand Rapids, MI 49501-0269

Authorization for release of personal and health information

PriorityHealth
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A. Member whose information is to be released

Member name		Date of birth _____ / _____ / _____
Address		
City	State	ZIP code
Contract number (on ID card)	Phone	

I request and authorize Priority Health* to release my personal and health information. This may include claims and billing information. It may also include medical records that Priority Health has received from medical practitioners, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis, hepatitis and demographic information.
(* "Priority Health" includes Priority Health/Priority Health Managed Benefits, Inc./Priority Health Insurance Company/Priority Health Government Programs, Inc.)

B. Type of information Priority Health may release (check ONE box)

☐ All of my information (including personal, health, demographic, claims, billing and medical records) **OR**
☐ Only my claims and billing information **OR**
☐ Other, such as information regarding a specific date of service or issue (explain) _____

_____

C. Who may receive your information?

Individual/entity name		Phone
Address		
City	State	ZIP code

D. What is the purpose of this Authorization? (check ONE box)

☐ At my request
☐ Other (explain) _____

E. When will this Authorization expire? (check ONE box)

Note: If I fail to list an expiration date or event below, this authorization will expire one year from the date signed.

☐ No expiration
☐ Upon my coverage termination
☐ On the following date _____ / _____ / _____ (MM/DD/YYYY)
☐ Upon my death
☐ Upon my written revocation
☐ On the following event _____

I understand that I may refuse to sign this Authorization. I may revoke this Authorization at any time by notifying Priority Health in writing at the address listed below. The revocation will not be effective for information that Priority Health discloses between the time that this Authorization is signed and when the revocation is received. If Priority Health requested this Authorization, I understand that I have the right to receive a copy of this Authorization after I sign it. I understand that Priority Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. I understand that the persons to whom information is disclosed under this Authorization may possibly redisclose the information to others without my knowledge or consent, and therefore, the privacy of my personal and health information may no longer be protected by law.

F. Signature required

If signed by a person other than the member, please check the relationship and provide proof of authority to do so:

☐ Parent of a minor child
☐ Power of attorney
☐ Legal guardian
☐ Personal representative of deceased member

Signature	Date _____ / _____ / _____
Printed name	

G. Finalize and send

- Form must be fully completed
- Submit form via one of the following
  - Scan and email to *HIPAA@priorityhealth.com*
  - Fax to: 616.942.0616
  - Mail to: Priority Health, MS 2005, 1231 East Beltline, N.E., Grand Rapids, MI, 49525-4501

This form satisfies all required elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).