Independent Health SELF-FUNDED SERVICES

UnitedHealthcare® Options PPO Network

Internal Appeal Filing Form

Please clearly PRINT all information

Use this form only if the member ID card says "Independent Health Self-Funded Services".

Member Name: _____ Member ID# :_____

Name of Person Completing Form *(if other than member)*: _____

Check all that apply to person completing form: ❑ Member ❑ Authorized Representative*

Contact Information of Person Completing Form:

Address: _____

Daytime Phone: _____

For Authorized Representative*

*Member Signature is Required: _____

**A valid HIPAA authorization form is required for the Plan to disclose protected health information to an authorized representative. If Independent Health Corporation does not have a valid HIPAA authorization on file for the authorized representative, a HIPAA authorization form will be mailed to the address above. An appeal submitted by an authorized representative cannot be processed without a valid HIPAA authorization.*

Briefly describe why you disagree with this decision:

You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim. Standard appeal decisions are made within 15 days.

_____

_____

Certification: *I hereby authorize Independent Health Self-Funded to release to the Peer Reviewer documents or information regarding the requested service(s). I acknowledge that Independent Health Self-Funded Services associates will access and review information to process this appeal.*

Member Signature: _____ Date: _____

Return this form and denial notice to: Independent Health Self-Funded Services, PO Box 1543, Buffalo, NY 14231

Keep copies of this form, your denial notice, and all documents and correspondence related to the service request.

Urgent appeals are available only for services that have not yet been provided.

*For URGENT appeals, the **treating physician must complete** the information below. Only in urgent situations may the provider act as the Authorized Representative without requiring the member's signature.*

❑ My patient's health would be in serious jeopardy if required to wait for a standard appeal decision.

❑ My patient would experience pain that cannot be adequately controlled if required to wait for a standard appeal decision.

Certification: *I hereby certify that the above, in my professional opinion, presents an urgent situation requiring that my patient's appeal (member) be expedited.*

Name of Treating Physician (please print): _____

_____ _____ _____

Treating Physician Signature *Date* *Phone*