Confidential

Independent Health

MEMBER APPEAL/COMPLAINT FORM

Member ID # _____

Member's Last Name | First Name | Middle Initial

Address (Number, Street, Apt.) | City | State | Zip Code

Telephone (Home) | (Business) | (Cell)

Email Address (optional)

If you are filing an appeal or complaint on behalf of another person, complete the information below. If the member has designated you as an authorized representative, provide a completed HIPAA authorization form or provide appropriate legal papers supporting your status as the member's designated representative. Your appeal or complaint will not be reviewed until the appropriate documentation supporting your status as the designated representative is received.

Your Last Name | First Name | Middle Initial

Address (Number, Street, Apt.) | City | State | Zip Code

Telephone (Home) | (Business) | (Cell) | Today's Date

Email Address (optional)

Signature

If you are completing this form electronically, please type in your full name.

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If you are the member's health care provider, you may appeal a retrospective adverse determination rendered by a utilization review agent. Please complete the following information. If this is not in regards to a retrospective adverse determination, you must include supporting documentation that you are the member's designated representative to file the appeal.

Physician's Last Name | First Name | Middle Initial

Practice Name and Address (Number, Street, Apt.) | City | State | Zip Code

Telephone (Business) | Today's Date

Physician ID # | Physician Signature
If you are completing this form electronically, please type in full name.

For more information, please contact Independent Health's Member Services Department at (716) 631-8701 or 1-800-501-3439 (TTY users call 711): Monday – Friday, 8 a.m. – 8 p.m.

☐ *Check this box if your health requires an expedited appeal. You can get an expedited appeal only if you are asking for coverage for medical care you have not yet received. You can ask for an expedited appeal if your health would be in serious jeopardy or you would experience pain that cannot be adequately controlled if required to wait for a standard appeal decision. If your health care provider believes an immediate appeal is warranted or the appeal involves continued or extended health care services, procedures or treatments, or additional services involving a course of continued treatment prescribed by a health care provider, Independent Health will automatically expedite the appeal.*

This Section Must Be Completed - Provide All Details Below
(Please Print)

I hereby authorize Independent Health to release to the members of the Member Appeals Committee any records, photographs, or information regarding the services in question. I acknowledge that Independent Health associates who need to know information pertaining to the services in question in order to process this appeal/complaint will have access to and may review such information.

Member's (or Member's Designated Representative's) Signature | Today's Date
If you are completing this form electronically, please type in your full name.

Date(s) of Service(s) | Provider(s) Involved

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Brief Description of Complaint or Appeal. Please use the space below.

Send this completed form (and any additional documentation) to:

Mail: Benefit Administration
P.O. Box 2090
Buffalo, NY 14231

Fax: (716) 635-3504

Email: appeals@independenthealth.com

Nondiscrimination statement and language assistance services

If you, or someone you're helping, have questions about Independent Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-501-3439.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independent Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-501-3439.

如果您，或是您正在協助的對象，有關於[插入 Independent Health 項目的名稱 Independent Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-501-3439。

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Independent Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-501-3439.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Independent Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-501-3439.

만약귀하또는귀하가돕고있는어떤사람이 Independent Health 에관해서질문이있다면귀하는그러한 도움과정보를 귀하의언어로비용부담없이얻을수있는권리가있습니다. 그렇게통역사와얘기하기 위해서는 1-800-501-3439 로전화하십시오.

Se tu o qualcuno che stai aiutando avete domande su Independent Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-501-3439.

אויב איר, אודר עמצער איר העלפסט, האט פראגעס וועגן, Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך אומזיסט. צו רעדן מיט דער אי'בערזעצער, קלונג 1-800-501-3439

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে Independent Health আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 1-800-501-3439

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Independent Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-501-3439.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Independent Health ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-501-3439

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Independent Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-501-3439.

اگر اپ کسی کو مدد دے رہے ہیں اور اپ دونوں کو سوال ہے Independent Health کے بارے میں، تو اپ دونوں کو اپنی زبان میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 1-800-501-3439 فون کریں۔

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Independent Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap angisang tagasalin, tumawag sa 1-800-501-3439.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Independent Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-501-3439.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Independent Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-800-501-3439.

Independent Health

Discrimination is Against the Law

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Independent Health's Member Services Department.

If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**

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