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| **Member/Applicant Information** |

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| ***Name*** ***(Last, First, Middle Initial):*** |  | ***Date:*** |  |
| ***Address:*** |  | ***City:*** |  | ***State:*** |  |
| ***Zip Code:*** |  | ***Phone:*** |  | ***Date of Birth:*** |  |

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| **Name of Individual filing form (if different from above)** |

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| ***Name*** ***(Last, First, Middle Initial):*** |  | ***Date:*** |  |
| ***Address:*** |  | ***City:*** |  | ***State:*** |  |
| ***Zip Code:*** |  | ***Phone:*** |  |

**Description of Appeal or Grievance:** (Please include dates, names, locations, also any other attempts to resolve the problem, attaching additional pages as necessary.)

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**What solution do you want?**

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| Continuation of Services |

For members with a Serious Mental Illness, your services under appeal will be continued during the appeal process, unless doing so poses a serious threat of harm to you or others.

For appeals relating to Title XIX or XXI services, please check *one* of the following:

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|[ ]  I am requesting that the services I am appealing be continued during the appeal process. I understand that if I lose my appeal, I may be required to pay for the cost of the services that were continued during the appeal process. |
|  |  |
|  |  |
|  | I do not want the services I am appealing to be continued during the appeal process. |
|[ ]   |
|  |  |
| **Member/Applicant Signature:** |  | **Date:** |  |
| If form is filled out by an individual other than the member, fill out the below information. |  |  |  |
| **Relationship to the Member/Applicant*:*** *(i.e. Provider, Health Care Decision Maker, Designated Representative****)*** |  |  |  |
| **Provider, Health Care Decision Maker, Designated Representative Signature:** |  | **Date:** |  |