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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:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 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. | | | |
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|  | I do not want the services I am appealing to be continued during the appeal process. | | | |
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| **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:** |  |