HIGHMARK HEALTH OPTIONS

Member Appeal Form

As a Highmark Health Options member, you can ask for an appeal. An appeal is a request for a review of a denied or limited health care service. This includes the:

- Type or level of service.
- Reduction, suspension, or termination of a service.
- Failure to provide a service in a timely manner.
- Highmark Health Options' denial to pay in whole or in part for a service.

Find more information in a document called "Notice of Adverse Benefit Determination" that was mailed to you.

When to file your appeal: This form must be completed and received at Highmark Health Options **within 60 days** of the date on the "Notice of Adverse Benefit Determination."

How to submit this form: Use the enclosed reply envelope to mail the completed form and any documents that will help us review your appeal request. If you do not have a reply envelope, mail to:
Highmark Health Options
Attn: Appeals and Grievances
P.O. Box 106004
Pittsburgh, PA 15230

What happens next: We will send you a letter letting you know we received your form. We will review the form and all supporting documents you have sent to us.

Need help?
Call Member Services at 1-844-325-6251 or read about the appeal process in your Member Handbook.

Use this form to request an appeal.

Please fill in as much of the form as you can and include as much information as possible. Here is what you need to provide:

Member information: Find this on your member ID card.

Patient information: Provide information about the person the request is for. If this person is the same as the member, leave this section blank.

Service/claim information: Tell us about the service, claim, or item about which you are appealing. Find this information on the "Notice of Adverse Benefit Determination."

Description of appeal: Tell us why you are requesting an appeal.

Print first and last name: Print the name of the person listed in the Patient Information section if that person is 18 or older, or print the name of the parent or guardian.

Signature: The person listed in the Patient Information section should sign if that person is 18 or older. If that person is under age 18, the parent or guardian should sign.

Choose an authorized representative:
You can choose to have an authorized representative help you with your appeal. To appoint an authorized representative, complete the Member Appeal Representation Authorization Form.

Last updated: July 28, 2021

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Member Information

Today's Date	Member ID Number	Date of Birth
First Name	Last Name	Primary Phone Number
Street Address		
City, State, ZIP		

Patient Information If same as above, leave blank.

First Name	Last Name	Date of Birth

Service Information

Provider Name	Date(s) of Service(s)
Provider Address	Provider Phone

Is this about a service that has been denied by Highmark Health Options?

Yes ☐ No ☐ Does not apply ☐

If you do not receive this service, is your life or health in immediate danger?

Yes ☐ No ☐ Does not apply ☐

Are you already receiving these services?

Yes ☐ No ☐ Does not apply ☐

Would you like to continue receiving services during the appeal process?

Yes ☐ No ☐ Does not apply ☐

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Reason for Appeal If more space is needed, use additional paper.

What do you want to happen as a result of your appeal?

Understanding Your Rights

1. You have the right to submit evidence or allegations of fact or law, in person or in writing.
2. You or your authorized representative have the right to review any information related to your appeal, free of charge.
3. You have the right to have a Highmark Health Options staff member assist you in the appeal process.
4. If you are a member's authorized representative or a provider filing on behalf of a member, you must obtain the member's written consent.

Print First and Last Name	**Signature**