Member Appeal Form

Complete and mail or fax to:
Allwell from Buckeye Health Plan| Appeals & Grievances/Medicare Operations
7700 Forsyth Blvd.|St. Louis, MO 63105
Fax: 1-844-273-2671

As a member of Allwell from Buckeye Health Plan you have the right to file an appeal for any denials related to medical services (Part C) or prescription drug (Part B and Part D) coverage. All **standard** appeal requests must be filed in writing. You may file **expedited*** appeal requests in writing or by calling Member Services at 1-855-766-1851 for HMO and at 1-866-389-7690 for HMO SNP, TTY: 711. From October 1 through March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends, and on Federal holidays. Allwell will give you a decision within the following timeframes from receiving your request:

Standard Medical Pre-Service Appeals: **30 calendar days**
Standard Prescription Drug Related Appeals: **7 calendar days**
(Including Part B Prescription Drugs)
Expedited Medical Pre-Service Appeals: **72 hours**
Expedited Prescription Drug Related Appeals: **72 hours**
(Including Part B Prescription Drugs)

Appeals related to payment issues For Part C and Part B drugs will be given a standard appeal decision within 60 calendar days of request receipt. For payment issues related to Part D drugs appeal decisions will be within 14 calendar days and payment within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we have up to 14 more calendar days for Part C Pre Service. We will tell you or your representative in writing if we decide to take extra days to make the decision.

Expedited appeals *mean you feel that using the standard deadlines could cause serious harm to your life or health or jeopardize your ability to regain maximum function. You must also be asking for coverage for medical care or a drug you have not yet received.*

Member's Name: Last _____ First _____

Medicare ID Number: _____

Member Date of Birth: _____

Relationship to Member* (please choose one): ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse

☐ Other: _____

**If other than "Self" is selected, proof of guardianship, power of attorney or an Appointment of Representative (AOR) form will be required. The AOR form can be found on our website.*

Name of Person Submitting the Appeal: _____

Phone Number(s): Home: _____ Cell: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Physician: _____

Appeal Type (please choose one):

☐ Standard Pre-Service (Medical) Appeal – (30 calendar days review)
☐ Expedited Pre-Service (Medical Appeal – (72 hours review)
☐ Standard Part B and Part D (Prescription Drug) Appeal – (7 calendar days review)
☐ Expedited Part B and Part D (Prescription Drug) Appeal – (72 hours review)
☐ Standard Payment Issues Appeal (Part C and Part B drugs) – (60 calendar days review)
☐ Standard Payment Issues Part D – (14 calendar days review)

What was denied? (Please include a copy of the denial letter.)

_____
_____
_____
_____
_____

Why do you think you should have <this/these> medical service(s)/prescription or payment?

_____
_____
_____
_____
_____

What is the best way to reach you regarding this appeal? (please choose one): ☐ Phone ☐ Email
☐ Other: _____

Signature of Person Appealing: _____ Date: _____

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For Administrative Use Only

Appeal Number: _____ *Date Received:* _____