INTERNAL APPEAL REQUEST FORM

Name of person filing appeal ______________________________

Relationship to covered person ☐ Covered Person/Applicant

☐ Authorized Representative *(please complete the Appointment of Authorized Representative section)*

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)			
Mailing Address	City	State	Zip code
Daytime Phone	Evening Phone		
Email Address	Fax		

COVERED PERSON/APPLICANT INFORMATION			
Name	ID Number		
Mailing Address	City	State	Zip code
Daytime Phone	Evening Phone		
Email Address	Fax		

TREATING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION			
Name	Phone Number		
Mailing Address	City	State	Zip code
Email Address	Fax Number		
Contact Person	Phone Number		

Internal Appeal Specifications

1. Are you requesting an expedited appeal because your health, life, or ability to regain maximum function may be in serious jeopardy while you wait up to 30 days for a decision on your appeal? ☐ Yes ☐ No
2. Are you requesting an expedited appeal because your physician certifies that your pain cannot be controlled while you wait up to 30 days for a decision on your appeal? ☐ Yes* ☐ No

3. Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review and your physician certifies that it is necessary? (Note: Request for External Review form is not required.) ☐ Yes* ☐ No

*If you answer yes to question 2 or 3 above, your physician must certify that your condition could, in the absence of immediate medical treatment, result in any of the following:

- Seriously jeopardize your life, health, or your ability to regain maximum function, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

You may also have your physician certify if you answer yes to question 1.

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

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Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize ______________________________ to pursue my appeal on my behalf.

______________________________ ____________________

Signature of Covered Person (or legal representative**) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I______________________________ hereby request an appeal. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider, and/or health plan issuer to release all relevant medical or treatment records to an Independent Review Organization, the Ohio Department of Insurance, and/or my health plan issuer. I understand that the Independent Review Organization, the Ohio Department of Insurance, and/or my health plan issuer will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

______________________________ ____________________

Signature of Covered Person (or legal representative**) Date

***Parent, Guardian, Conservator, or Other - please specify*

Send this form and a copy of your notice of final adverse benefit determination to one of the following:

Grievance and Appeal Coordinator
PO Box 6029 Canton, OH 44706 | Fax: 330-363-3066 | Email: Aappeals@aultcare.com

Be certain to keep copies of this form, your Notice of Final Adverse Benefit Determination, and all documents and correspondence related to this claim.