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FIRST LEVEL- INTERNAL APPEAL REQUEST FORM

Please keep copies of this form, your Adverse Benefit Determination & all documents/correspondence related to this claim.

Date: _____

Name of person filing appeal: _____

Relationship to covered person: ☐ Member/Applicant

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

How would you like for us to contact you? ☐ Phone ☐ Fax ☐ Email ☐ Mail

Contact Information of Authorized Representative *(If Applicable)*:

Name:	
Mailing Address:	
Daytime Phone:	Evening Phone:
Email Address:	Fax:

Contact Information of Member/Applicant Information:

Name:	
ID Number:	
Mailing Address:	
Daytime Phone:	Evening Phone:
Email Address:	Fax:

Treating Physician/Health Care Provider Information:

Name:	
Mailing Address:	
Contact Person:	Phone:
Email Address:	Fax:

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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 Internal Appeal and/or Expedited External Review and your physician certifies it necessary? *(Note: Request for External Review is not required.)*

☐ Yes* ☐ No

** If you answer Yes to question 2 or 3 above, your physician must complete the Treating Physician Certification Form for Internal Appeal and/or External Review. You may also have your physician complete The Certification Form if you answer Yes to question 1.*

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

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 health care 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 Member or Legal Representative: _____

Date: _____

Please send this form and a copy of your Notice of Adverse Benefit Determination to one of the following:

Toll Free: 1-866-965-3784

Toll Free: 1-866-999-7736

Email Address: appeals@procarerx.com

Mailing Address: ProCare Pharmacy Care
3891 Commerce Parkway
Miramar, FL 33025