MEDICAL MUTUAL®
CAROLINA CARE PLAN | CONSUMERS LIFE

MEMBER APPEAL FORM

DATE REQUEST SENT TO MEDICAL MUTUAL _____

Please print or write legibly. Please refer to the attached instructions if there are questions about this form.

PATIENT AND/OR POLICY HOLDER INFORMATION

Last name of patient	First name of patient	MI	Policy ID #	Date of birth (MM/DD/YYYY)

Name of authorized representative pursuing appeal, if different from above **(See instructions, page 2)**			
Relationship to patient			
Mailing address	City	State	ZIP Code
Daytime telephone number	Evening telephone number		

TYPE OF REQUEST

Please check one

- ☐ Benefit/coverage issue
- ☐ Dental service
- ☐ Medical necessity denial – post-service (service already provided)
- ☐ Medical necessity – pre-service (service not yet received)
- ☐ Prescription drug
- ☐ Vision service
- ☐ Other _____

CLAIM/CASE NUMBER INFORMATION

Date of service	Claim #	Case # from denial letter

REASON FOR APPEAL

Explain what decision you are appealing and why you disagree with this decision. (Attach additional sheets of paper if needed)

Please attach all documentation that shows why you believe your plan should cover this claim or authorize a service, including medical records and supporting documentation (e.g., letter from your doctor, office records, surgical reports, photos, lab reports, X-ray reports). This will help facilitate the appeals process.

Mail to: Medical Mutual
Member Appeals
P.O. Box 94580
Cleveland, OH 44101-4580

Fax to: 216.687.7990 or 866.691.8260

Be certain to keep copies of this form, your Explanation of Benefits or denial letter, and all documents and correspondence related to this case.

_____ _____

*Signature of Policyholder or Patient (or legal representative**) Date

* Signature is required in order for the appeal request to be accepted.
** Parent, Guardian, Conservator or Other – please specify.
If you are acting on behalf of the above-named member as a legal representative, please provide the appropriate legal documentation (example: Power of Attorney).

MEMBER APPEAL FORM INSTRUCTIONS

Please note: If you have an urgent care appeal for services you have not yet received, you may want your physician to call the number for Providers on your ID card. For more information on filing an appeal, please refer to your Certificate or Benefit Book. An urgent care claim is any pre-service claim for medical care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize your life or health or your ability to regain maximum function or (b) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

What is an appeal?

An appeal is a formal request to change a previous decision made by Medical Mutual that resulted in a denial, reduction or termination of a requested healthcare service in whole or in part. The patient or authorized representative may appeal any adverse decision (including a denial or reduction in benefits) for care or service.

How long do I have to send my appeal?

For a first level appeal, you must send your appeal to Medical Mutual within 180 days of receiving your initial denial notice or as otherwise indicated in your Certificate or Benefit Booklet for subsequent appeals, if applicable.

When will I receive a written response?

A written response will be sent to you within 30 days of Medical Mutual receiving your request, or as indicated in your Certificate or Benefit Booklet.

If I am filing an appeal, what information should I send?

Please send all information you want considered in the review along with your appeal request, any letter of denial you may have received from Care Management and the applicable records listed in the Medical Records and Supporting Documentation section below.

Who do I contact for help?

For assistance in completing this form, call Customer Service at the number on your ID card.

How do I submit my appeal?

You may submit the form and records by fax (216.687.7990 or 866.691.8260), online (MedMutual.com) or mail to:

Medical Mutual
Member Appeals
P.O. Box 94580
Cleveland, OH 44101-4580

PATIENT AND/OR POLICY HOLDER INFORMATION

Complete in full: patient name, ID number, date of birth, mailing address and telephone number(s).

If a person other than the patient is pursuing the appeal, fill in the authorized representative's name and relationship to the patient. A *Designation of Authorized Representative for Appeals or to Request Information Form* must also be completed. Visit MedMutual.com to download this form.

AUTHORIZED REPRESENTATIVE

You have the right to allow someone to act on your behalf throughout the appeal process. Simply send a completed *Designation of Authorized Representative for Appeals or to Request Information Form* along with the *Member Appeal Form.* Visit MedMutual.com to download this form.

For parents or guardians to act on behalf of dependents age 18 or older, the dependent may need to send a completed *Designation of Authorized Representative for Appeals or to Request Information Form* to Medical Mutual before the appeal process can begin for certain types of cases.

TYPE OF REQUEST

Please check one box that best describes your appeal request.

☐ **Benefit/Coverage issue:** A service or procedure was not covered according to your contract, or was reduced or limited in coverage.

☐ **Dental service:** A service or procedure rendered by a dental professional was denied as not clinically necessary, not a covered benefit under your contract or was reduced or limited in coverage. (See *Oral Surgery* under *Medical Records and Supporting Documentation.)*

☐ **Medical necessity post-service:** A service or procedure already received was denied as not being medically necessary. (See *Medical Records and Supporting Documentation.)*

☐ **Medical necessity pre-service:** A service or procedure not yet received was denied as not being medically necessary. (See *Medical Records and Supporting Documentation.)*

☐ **Prescription drug:** A prescription drug was denied as not a covered benefit or because you are not eligible for prescription drug coverage.

☐ **Vision service:** A service, procedure or product rendered by or obtained from an eye care professional or center was denied. (See *Medical Records and Supporting Documentation.)*

☐ **Other:** Any item, procedure or service not listed as a *Type of Request.*

CLAIM/CASE NUMBER INFORMATION

Date of service: The date on which the service or procedure was received, as listed on the Explanation of Benefits. (If services were not yet received, omit.)

Claim #: Found in the upper right corner of your Explanation of Benefits. (If services were not yet received, omit.)

Case #: Found on the upper right corner of a denial letter from Care Management. (Omit if a denial letter from Care Management was not received.)

REASON FOR APPEAL

Explain what decision you are appealing and why you believe the decision should be overturned in your favor.

MEDICAL RECORDS AND SUPPORTING DOCUMENTATION

Along with the *Member Appeal Form,* attach or fax the following, as applicable:

Allergy:

- All office notes for the services in question
- Description of all medications given, including dosage

Ambulance:

- Emergency room reports plus:
  - Air:
    - Flight records, including a breakdown of charges that identify the number of air miles
    - A letter of medical necessity that substantiates the need for transfer
    - The place or origin of flight and the destination
  - Ground:
    - The run report from the ambulance company
    - A letter of medical necessity that supports the need for transport

Anesthesia:

- Hospital anesthesia records
- Operative reports

Durable medical equipment:

- Complete description of the equipment
- Form or letter of medical necessity
- Detailed medical history
- Approximate cost of the equipment or an invoice

Emergency room:

- Complete emergency room records
- Readable copies of physicians' and nurses' notes

Home Healthcare:

- Physicians' notes
- Physician-signed treatment plan
- All notes for any services being performed by the agency

Inpatient stays for Behavioral Health, Hospital Inpatient, Skilled Nursing Facility and Residential Treatment Care Facilities:

- All documentation related to the service including inpatient medical records

Inpatient medical care, concurrent medical care by more than one doctor or consultation:

- All physicians' signed progress notes for the date of service in question

Maternity:

- Detailed patient medical history
- Test results
- Labor and delivery records

MRI/MRA:

- MRI/MRA report
- Patient history and X-ray results
- Records of any trials or conservative treatments, such as medication use or physical therapy

Office visit and office consultation denials:

- All office notes for the service in question

Private duty nursing:

- Physician's orders
- All hourly nursing documentation

MEDICAL RECORDS AND SUPPORTING DOCUMENTATION CONTINUED

Surgery: When questioning the level of payment or the denial of a surgical procedure, an operative report is required.

- Cosmetic procedures
  - Operative report
  - Radiology reports or other test results
  - Office notes
  - Any appropriate pre- and post-surgery photos
- Weight-loss surgery
  - Documentation of weight history
  - Record of most recent conservative weight loss attempts
  - Psychiatric report
  - Documentation of any medical conditions and the treatment rendered for these conditions
- Oral Surgery
  - Dental office notes
  - Operative report
  - Anesthesia records
  - All pre- and post-service X-rays

Testing that includes laboratory, pathology and radiology, including scans:

- Testing results
- Doctor's office notes

Therapy that includes chiropractic, physical therapy, speech therapy and/or occupational therapy:

- Initial evaluation
- Progress notes
- X-ray reports (if applicable) or other test results
- Re-exam findings
- Treatment plan

Hearing:

- Office notes
- Test results (if appropriate)
- Medical necessity information

Vision service:

- Office notes
- Test results (If appropriate)
- Medical necessity information