Alluma™

Internal Appeal Filing Form

Member Name Member Date of Birth

Member ID Case #

Person filing request for appeal:

Select one

Enrollee/Patient Authorized Representative Health Care Provider Parent of minor child under 18

Contact information of person filing request for appeal (if different from patient):

Name of person filing request

Address

City State Zip

Daytime phone Email Fax

If person filing request for appeal is other than patient, patient must indicate authorization by signing here*:

Patient Signature ____

*This requirement may be waived when a health care professional with knowledge of the patient's medical condition makes a request for an urgent/expedited review on behalf of the patient.

I am requesting an urgent/expedited review* because the member's health, life or ability to regain maximum function may be seriously jeopardized or, in the opinion of member's physician, member may experience severe pain that cannot be adequately controlled while **waiting for a standard coverage determination?**

Yes No

*If you require an urgent External review, you may also need to submit an External Appeal Filing Form, if applicable, along with this form. Contact Alluma for this form.

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)**:**

Send this form AND your denial notice to: Alluma - Attn: Clinical Department, PO Box 14651, Saint Louis, MO 63166, or fax to 833-951-1683, or call 1-800-818-9290.

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.