Alluma™

Internal Appeal Filing Form

CONTACT INFORMATION FOR PATIENT FILING APPEAL

Member name _____ Member date of birth _____

Member ID _____ Case # _____

Select one:

◯ Enrollee/Patient ◯ Authorized Representative ◯ Healthcare Provider ◯ Parent of minor child under 18

CONTACT INFORMATION OF PERSON FILING 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*:

*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.

Patient signature

_____

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

BRIEFLY DESCRIBE WHY YOU DISAGREE WITH THIS DECISION (please attach medical records or additional information such as a physician's letter, bills, 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.**

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