Ohio Medicaid Managed Care Entity

Member Appeal Form

If you do not agree with a decision made by your managed care entity (MCE), you should contact the MCE as soon as possible. You, or someone you want to speak for you can contact the MCE using this form.

Instructions: Complete Sections I and II of this form entirely, describe the issue(s) in as much detail as possible, and submit the completed form to the appropriate MCE. To ensure a decision can be made by the MCE, the following documentation should be submitted with the form:

- Attach *copies* of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

Section I – Member Information		
Member Name		**Date of Request** (mm/dd/yyyy)
Member ID Number	**Member Phone Number**	**Date of Birth** (mm/dd/yyyy)
Member Address		
Reason For Request ☐ Service(s) denied, reduced, or ended ☐ Untimely decision on prior authorization request ☐ Payment or claim denied ☐ Other (explain):		
☐ I believe waiting on this decision could seriously jeopardize my life, physical or mental health, or ability to attain, maintain or regain maximum function. I understand by checking this box that it may reduce the amount of time that myself and/or provider have to send in additional information regarding my appeal unless an extension is requested. If no extension is requested and meets criteria, I will receive a decision within 72 hours. ☐ I believe waiting on this decision would not jeopardize my health. Unless an extension is requested, I will receive a decision on my appeal within 15 calendar days.		
Section II – Description of Specific Issue *Please state all details relating to your request including names, dates, places, provider information, and prior authorization request number if known. Attach another sheet of paper to this form if more space is needed.*		
By signing below, you agree that the information provided is true and correct.		
Member's Signature		**Date** (mm/dd/yyyy)
If someone else is completing this form for you, you are giving written consent for the person named below to submit on your behalf. By signing below, your authorized representative agrees that the information provided is true and correct.		
Member's Authorized Representative Name (if applicable)		**Relationship to Member**
Authorized Representative Signature (if applicable)		
☐ *Check this box if you are a provider submitting this form on behalf of a member. In accordance with Ohio Administrative Code rule 5160-26-08.4, any provider acting on the member's behalf must have the member's written consent to file an appeal. The MCE will begin processing the appeal upon receipt of written consent.*		
Contact and Submission Information. Call, write or fax:		
Molina Healthcare of Ohio, Inc. Grievance and Appeals Unit P.O. Box 182273 Chattanooga, TN 37422		Molina Healthcare Member Services: (800) 642-4168 Hearing Impaired TTY/Ohio Relay: (800) 750-0750 or 711 Monday - Friday, 7 a.m. to 7 p.m., local time Fax Number: (866) 713-1891