Molina Healthcare of Iowa Medical Appeal Request

If you want to appeal the decision we have made, you may fill out the form or call us within sixty (60) calendar days of the date on the Notice of Adverse Benefit Determination.

If your health care provider thinks your life or health is in immediate danger because of the decision in the Notice of Adverse Benefit Determination, he/she can ask for an expedited appeal by either calling us or sending us this form.

If you want help completing this form, please call 844-236-0894.

Is the member or a health care provider requesting this appeal? ☐ Member ☐ Health Care Provider

Date: _____ Member ID#: _____

Member last name:_____

Member first name:_____ Member middle initial: _____

Current Address:_____ Apt. if app:_____

City:_____State:_____Zip:_____

Phone number:_____

Doctor's Name:_____

What kind of an appeal is this? Please check one:

☐ **Standard**

☐ **Expedited** - If your provider thinks your life or health is in immediate danger, you may ask for an expedited (quick) appeal decision.

☐ **Continuation of Benefits** - <u>You can only ask that you keep getting services</u> if Molina has terminated, suspended, or reduced a service that Molina had previously authorized. You must request continuation of those services within ten (10) calendar days of this Notice of Action. It also means that you may have to pay Molina for these services if the appeal decision is to deny the services.

What results are you hoping for from this hearing? _____

_____

_____

Please attach any information that will help us understand your medical case and your appeal, and send to:

Appeals & Grievances
Molina Healthcare Inc.
PO Box 93010
Des Moines, IA 50393
Fax 833-832-1922

Please note that if you choose someone else to file the appeal, you must fill out the attached "Authorized Representative for Managed Care Appeals" form below.

IOWA HHS

Iowa Department of Health and Human Services

Authorized Representative for Managed Care Appeals

This form shall be completed by the Medicaid member or their parent, if the member is a minor. Complete this form to appoint an individual, organization, or provider to act on your behalf during theappeals process. The member and the authorized representative must both sign this form. Legal documentation such as a court order establishing legal guardianship, or a power of attorney can be submitted instead to designate a representative.

Appellant Information

First and Last Name		Date of Birth
Case Number	Medicaid ID Number	Telephone Number
Parent's Name, if appellant is minor (under age 18)		
Brief Explanation of What is Being Appealed		

By signing this form, I understand:

- This authorization is at my request. I have the right to refuse to sign this form and that it is strictly voluntary.
- My signature does not waive my right to represent myself.
- My signature does not waive my financial obligation should the appeal be decided in theDepartment's favor.
- I authorize my Authorized Representative to act on my behalf during my appeal and to have access to all protected health information regarding my appeal and agree that this informationmay be disclosed to other persons in connection with this appeal.
- This authorization automatically expires at the end of the appeals process or if I revoke this permission in writing. I can revoke this authorization by sending a written request by mail or faxto:
  Department of Human Services, Appeals Section, 1305 E Walnut Street 5th Floor, Des Moines, IA 50319,
  Fax: (515) 564-4044.

Signature of Appellant or Parent, if appellant is a minor	Date Signed

Appellant Representative Information

Authorized Representative First and Last Name		
Organization or Provider Business Name		
Representative Mailing Address		
City	State	ZIP Code
Relationship to Representative	Representative Telephone Number	

By signing this form, the Authorized Representative understands:

As a condition of serving as an authorized representative, I agree to abide by relevant state and federal laws concerning conflicts of interest and confidentiality of information.

If the appellant is physically unable to sign, I, the Authorized Representative, certify that (appellant) _____ is physically unable to sign this form. Describe the physical incapacity affecting the appellant.

_____

_____

_____

Signature of Authorized Representative	Date Signed

NOTE: This form is not valid for appellants who are mentally unable to sign. If the appellant is mentally unable to sign this form, the person acting on their behalf must submit legal proof of guardianship with the appeal.

Please submit the form to your managed care organization or to the Department of Human Services at the address below.

Amerigroup Iowa Inc Grievances and Appeals Department 4800 Westown Pkwy Ste 200 West Des Moines, IA 50266	Iowa Total Care Grievances and Appeals Department 1080 Jordan Creek Pkwy, Ste 100S West Des Moines, IA 50266 FAX: (833) 809-3868	Molina Healthcare Appeals and Grievances PO Box 93010 Des Moines, IA 50393
Delta Dental of Iowa Attn: DWP Appeals andComplaints PO Box 9040 Johnston, IA 50131-9040	MCNA Dental Attn: Grievances and AppealsDepartment 200 West Cypress Creek Road,Suite 500 Fort Lauderdale, FL 33309	Department of Health and Human Services Appeals Section 1305 E Walnut St 5th Floor Des Moines, IA 50319 FAX: (515) 564-4044 Email: appeals@dhs.state.ia.us