MEDICAL APPEAL REQUEST

If you want to appeal the decision we have made, you can write a letter or fill out this form and send it to us within 180 calendar days from the date on the Notice of Adverse Benefit Determination for a regular (standard) appeal. You can also call us within 180 calendar days from the date on the Notice of Adverse Benefit Determination. If you call us first, you must still send a letter or this form to us within 15 business days after calling us.

If you or your doctor thinks your life or health is in immediate danger because of the decision in the Notice of Adverse Benefit Determination letter, you or the doctor acting on your behalf can ask for an expedited (quick) appeal by calling us. If you call us to request a quick appeal, you do not need to send Molina this form.

If you want help filling out this form, please call (833) 644-1623.

Who is requesting this appeal (check one)?

☐ Member ☐ Health Care Provider Date: _____

MEMBER INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MI: _____

Member Address: _____

City: _____ State:_____ ZIP: _____

Member Phone: _____ Member Email: _____

Reason for Appeal: __ _____

_____

_____

HEALTH CARE PROVIDER INFORMATION:

Doctor Name: _____

Doctor Address: _____

City:_____ State: _____ ZIP: _____

Name of Contact at Doctor's office: _____

Doctor Phone: _____ Doctor Fax: _____

Reason for Appeal: _____

_____

_____

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

Molina Healthcare of Illinois, Inc.
Attn: Member Appeals Department
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Toll Free: (833) 644-1623

Fax: 855-502-5128

Email: MHI.IL.Appeal@MolinaHealthCare.Com

Authorized Representative Permission Statement

If your health care provider or another individual is filing the grievance for you, you **must** give your written permission.

I, _____ (your name), give my permission

for_____ (designee) to file this Grievance Form on my behalf.

_____ _____

Member Signature Date

Check this box to have your appeal processed as expedited ☐

NOTE: All requests for an expedited appeal **MUST** be accompanied by supporting documentation from the requesting provider indicating the reason for the expedited request.