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.

Contact and submission information for MCEs can be found on page 2 of this document.

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		
OhioRISE | aetna	Phone: 833-711-0773 Fax: 833-928-1259	Appeal and Grievance Department PO Box 81139 5801 Postal Road Cleveland, OH 44181
Anthem	Phone: 844-912-0938 Fax: 866-387-2968 Email: ohioga@anthem.com	Medical Appeals Anthem Blue Cross & Blue Shield PO Box 62429 Virginia Beach, VA 23466
AmeriHealth Caritas Ohio	Phone: 833-641-3290 Fax: 833-329-2164	PO Box 7346 London, KY 40742
buckeye health plan	Phone: 866-246-4358 Fax: 866-719-5404	4349 Easton Way, Suite 120 Columbus, OH 43219
CareSource	Phone: 800-488-0134 Fax: 937-531-2398	Form may also be submitted on the member or provider portal
Humana Healthy Horizons in Ohio	Fax: 800-949-2961	Humana Healthy Horizons Attn: Grievance and Appeal Department PO Box 14546 Lexington, KY 40512
MOLINA HEALTHCARE	Phone: 800-642-4168 Fax: 866-713-1891	Molina Healthcare of Ohio Attn: Grievance and Appeal Department PO Box 349020 Columbus, OH 43234
United Healthcare Community Plan	Standard Fax: 801-994-1082 Expedited Fax: 801-994-1261	UnitedHealthcare Community Plan Appeals and Grievances Department PO Box 31364 Salt Lake City, UT 84131
gainwell (SPBM)	Phone: 833-679-5491 Email: OH_MCD_PBM_GA@gainwelltechnologies.com	