NOTICE OF APPEAL REQUEST FORM

Date: ____________________ URA License Number: 1725137

Name of Person Requesting the Appeal (Print)

____
(Last Name) (First Name) (M.I.)

Phone: ______________________
(XXX-XXX-XXXX)

Relationship to the Member (check one)

________ Provider ________ Self
________ Person acting on behalf of the member

____
Relationship

Member Contact Information

Member ID Number ________

Name ____
(Last Name) (Frist Name) (M.I.)

Date of Birth __ __ / __ __ /__ __ __ __

Address ______________________________________ City ________________ Zip Code ________

Phone: ______________________ State ________
(XXX-XXX-XXXX)

Provider Information: ***Please provide information about the physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the member.***

Name ____

Address ____ City ________________ Zip Code ________

Phone: ______________________ Fax: ______________________ (if applicable) State ________
(XXX-XXX-XXXX) (XXX-XXX-XXXX)

Information regarding the appeal

Original Date of Service ______________________ Date of Denial ______________________

Reason for appeal: ____

Please submit and additional documentation that you would like considered with this appeal.

RELEASE OF INFORMATION

(Signature is required for an appeal of a notice if submitted by the provider on behalf of the member)

I, ______________________________, the member, or his/her legal guardian, do hereby authorize the release of all necessary medical records and other documents that are relevant to this review.

____
(signature)

Return this form to:

Sendero Health Plans
Attn: Appeals
2028 East Ben White Blvd.
Suite 400
Austin, TX 78741
Fax: (512) 901-9724

If you have any questions concerning the appeal process, please call us at 1-855-297-9191

HS-UM139_012816