

NOTICE OF APPEAL REQUEST FORM

Date: URA License Number: 1725137

The of Person Requesting the Appeal (Print)

Relationship to the Member (check one)

Relationship	Name of Person Requesting the Appeal (Print)					Relationship to the Member (check one)			
Phone: (XXX-XXX-XXXXX)						Provider		Self	
Member Contact Information	(Last Nam	e)	(First Name)	(M.I.)	_	Person act	ing on beha	alf of the member	
Member Contact Information Name Cast Name City Zip Code	Phone:								
Name Clast Name City Zip Code		(XXX-XXX-XXXX)			<u> </u>	Relationship			
City Zip Code	Member Contact Information					Member ID Number			
Address City Zip Code Phone: State City Code	Name						Date of Birt	h//	
Phone: (XXX-XXX-XXXX)		(Last Name)	(Frist Name)		(M.I.)				
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)	Address				City		_	Zip Code	
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: (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)	Phone:							State	
Address City Zip Code Phone: Fax: (if applicable) State (XXX-XXX-XXXX) (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)		(XXX-XXX-XXXX)							
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(XXX-XXXXXX) (XXX-XXXXX) 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)	Phone:			Fax:					
Original Date of Service Date of Denial		(XXX-XXX-XXXX)				()	,		
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)	Informatio	on regarding the appe	al						
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RELEASE OF INFORMATION (Signature is required for an appeal of a notice if submitted by the provider on behalf of the member)	Reasor	n for appeal:							
RELEASE OF INFORMATION (Signature is required for an appeal of a notice if submitted by the provider on behalf of the member)		Diago	submit and additional	documentation the	ot vou would	lika cansidarad with th	nic annoal		
(Signature is required for an appeal of a notice if submitted by the provider on behalf of the member)		Please	Suprint and additional	documentation tha	n you would	tike considered with ti	из арреас.		
I,, the member, or his/her legal guardian, do hereby authorize the release of all necessary	(Signature is required for an appeal of a notice if submitted by the provider on behalf of the member)								
medical records and other documents that are relevant to this review.	medical re	ecords and other docu	ments that are releval	nt to this review.					
(signature)					_		(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