SENDERO HEALTH PLANS

URA License Number: 1725137

IdealCare NOTICE OF APPEAL REQUEST FORM

Date: _____

Name of Person Requesting the Appeal (Print)

_____

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

Phone Number: _____ _____ - - - - -
(area code) (number)

Relationship to the Member: *(check one)*

☐ Self

☐ Provider

☐ Person acting on behalf of Member

Relationship: _____

Member Contact Information:

Member ID Number _ _____

Name _____

Date of Birth: _ _/_ _/_ _

Address _____ City _____ State _____ Zip Code _____

Phone Number: _____
(area code) (number)

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 _____ State _ _ Zip Code _____

Phone Number: _____ _____ Fax Number: _____ *(if applicable)*
(area code) (number) (area code) (number)

Information Regarding the Appeal:

Original Date of Service: _____ Date of Denial: _____ Reason for Appeal _____

_____

Please submit any 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
(print name)
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.,
Ste. 400 Austin, Texas 78741
Fax: 512-901-9724

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