SENDERO HEALTH PLANS

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 _____ Date of Birth __ __ / __ __ /__ __ __ __
(Last Name) (Frist Name) (M.I.)

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
P.O. Box 17247
Austin, Texas 78760
Fax: (512) 901-9724

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