RECONSIDERATION REQUEST ON BEHALF OF ENROLLEE (MEMBER APPEAL)

TO

<Name of Medicare Advantage Plan>

Department: Grievances and Appeals

Fax Number:

 # Pages:

FROM

Physician: NPI#

Correspondence Address:

Return Fax:

Return Phone:

Date(s) of Service:

Enrollee Name:

Member Number:

☐ I am initiating this appeal on behalf of and with agreement of the enrollee

☐ Attachments:

TYPE OF RECONSIDERATION REQUESTED

☐ Expedited (Fast) Concurrent Level of Care Reconsideration Request

☐ Expedited (Fast) Pre-service Reconsideration Request

☐ In my judgment, the standard decision timeframe would adversely impact the enrollee

REASON FOR RECONSIDERATION

<Outline brief reasons for appeal.>

MAO's must provide coverage for all services that are covered by Part A and Part B of Medicare, and comply with coverage guidelines in original Medicare manuals and instructions. (42 CFR § 422.101)
If a fully favorable decision is not rendered, we request to receive a copy of the case file forwarded to Maximus so that I may supplement the clinical information as necessary.

_____ <Physician Name>, MD _____

Date