APPEAL FORM

To initiate an appeal, complete and submit this form to MedImpact's Appeal Coordinator at the address listed below. Or, fax it to the Appeal Coordinator at (858) 790-6060. **Include a copy of the denial letter with the completed appeal form.**

Date: _____ PA Reference # (found on denial letter): _____

Member Information

Name: _____ ____ _____ DOB: ____/____/_____
First Name MI Last Name

Group/Health Plan Name: _____ Group/Health Plan ID #:_____

Address:_____ City: _____ State: _____ Zip:_____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Physician Information (name and phone number are required)

Name: _____ _____ Physician ID#: _____
First Name Last Name

Address:_____ City: _____State: _____Zip:_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____ DEA#: _____

Appeal Information /Description of Appeal

Date drug was denied: _____ Drug name, strength, and duration denied: _____

Provide a detail description of the reason for this appeal (attached additional sheets if necessary):

_____

_____

_____

_____

Authorized Representative Information

If someone other than the member is filing this appeal, please provide the following information:

Name: _____ Relationship to Member:_____
First and Last

Address:_____ City: _____ State: _____

Zip:_____ Daytime Telephone: (_____)_____-_____

I Hereby Attest That The Above Information Is True:

_____
Member's Signature Date

_____
Representative's Signature (if one has been assigned) Date

☐ *Check this box if you believe that you need a decision within 72 hours.*

Mailing Address: 10181 Scripps Gateway Ct, San Diego, CA 92131
Appeal Coordinator Fax: (858) 790-6060
Phone: 800.788.2949

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