**A Qualified Health Plan Issuer in the Health Insurance Marketplace**

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# INTERNAL APPEAL REQUEST FORM

**Name of person filing appeal:** _____

**Relationship to covered person:** **Covered Person/Applicant**

**Authorized Representative (please complete the Appointment of Authorized Representative section)**

**How would you like us to contact you?** **Phone** **Fax** **Email** **Mail**

## Internal Appeal Specifications

1. **Are you requesting an Expedited Internal Appeal because you are currently hospitalized?**

   **YES*** **NO**

2. **Are you requesting an Expedited Internal Appeal because in the opinion of your treating provider, review under the standard Internal Appeal time frame (of up to 30 days) could, in the absence of immediate medical attention, result in placing your health or the health of your unborn child in serious jeopardy, cause serious impairment of your bodily functions, or cause you serious dysfunction of a bodily organ or part?**

   **YES*** **NO**

3. **Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review that in (Note: Request for External Review form is not required.)**

   **YES*** **NO**

***If you answer YES to any of the questions above, your treating provider must complete the Treating Provider Opinion Form for Internal Appeal and/or External Review.**

**Briefly describe why you disagree with this decision (you may attach additional information, such er documents to support your claim):**

_____

_____

_____

## Covered Person/Applicant Information

**Name:** **ID Number:**

**Mailing Address:**

**Daytime Phone:** **Evening Phone:**

**Email Address:** **Fax:**

**Treating Physician/Health Care Provider Information**

**Name:**

**Mailing Address:** **Phone Number:**

**Email Address:** **Fax Number:**

**Contact Person:** **Phone Number:**

**Appointment of Authorized Representative (complete when someone else is representing you in this appeal)**

**You may represent yourself, or you may ask another person, including your treating provider, to act as your authorized representative. You may revoke this authorization at any time.**

**I, _____, appoint _____,**
**Your Name**

## Consent to Release Medical Records

**To request an Internal Appeal and/or an External Review of your Adverse Benefit Determination,**