Health Tradition Health Plan
PO Box 188
La Crosse, WI 54602-0188
1-888-459-3020 (Toll-free) or 608-781-9692

Member Appeal Form

Premier, Premier One, Premier Plus and 65Plus

Today's Date: ___________

Name of person appealing: ________________________Relationship:_____________________

Phone: (Day)______________________________(Evening)_____________________________

Member Name:____

Member Street Address:____

City, State, Zip:____

Employer: ____

Health Tradition Plan: □ PREMIER-HMO □ PREMIER PLUS-POS □ Premier One
□ 65Plus

Patient's Name:____

Patient's Member I.D. ______________________________Date of Birth:__________________

Summary of Complaint:

1) Date problem happened: ____
2) Problem (describe what happened; please give names of individuals; attach additional pages if necessary): ____

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-PLEASE DO NOT WRITE BELOW THIS LINE-

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Member Appeal Form
Continued

3) How would you like to see this problem fixed? ___________________________________
____
____
____

4) Has anyone tried to help you with this problem already? Yes ______ No _______
If yes, who? (please give name & phone number) _________________________________

5) I want to appear before the Grievance Committee. □ yes □ no

6) Do you want to submit written questions to the person or persons responsible for making the decision? □ yes □ no
Please list questions below.
____
____
____
____
____

7) Do you, or your representative, wish to attend the meeting in person? □ yes □ no

If you want an authorized representative to act on your behalf in the appeal, we require a signed Authorized Representative Form or proof of Power of Attorney . Medical Information will not be released to your representative in the course of the appeal unless a Medical Release of Information Form is also signed. Please contact the Plan at the address or phone numbers above to request assistance with this process. Under certain extenuating circumstances a signature is not possible. Contact us for more information so that we can assist you in meeting your needs.

8) Would you prefer to attend via telephone conference call? □ yes □ no

9) Do you need any special arrangements? □ yes □ no

Please describe any special needs:

Signature____

Health Tradition Appeals Process

Your grievance will be reviewed as soon as Health Tradition receives this completed form. We may need to research the issues to resolve the problem. The Grievance Committee will attempt to resolve your complaint within 15 days for those situations where the service has not yet been provided; and 30 days for those situations where the service has already occurred. If we cannot resolve your complaint in the 15- or 30-day time frame, we will notify you in writing on or before day 15 (before service) or day 30 (after service) with the reason for the delay.

If you should receive a denial **AND** the denial involved a medical decision, experimental treatment, or on the basis of a pre-existing condition **AND** the care cost $292 or more, you may have the right to an independent external review under certain circumstances. You will be provided with the appeal process should you receive this type of denial.

Please refer to Article VIII of your member certificate or summary plan description for the appeals process. You may contact us through the local or toll-free number listed above if you have any questions.