HealthTradition
HealthPlan
WITH MAYO CLINIC HEALTH SYSTEM

Member Appeal Form

1-888-459-3020 (Toll-free) or 608-781-9692

Today's Date: _____

Name of person appealing:_____

Relationship: _____Phone_____

Member Name: _____

Member I.D._____ Date of Birth: _____

Member Street Address:_____

City, State, Zip:_____

Employer: _____

1. Reason for Appeal (describe what happened; please give names of individuals; list claim #s; attach denial letters; attach additional pages if necessary):_____

HealthTradition
Health Plan
WITH MAYO CLINIC HEALTH SYSTEM

Cont…_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

****Please include all documents including copies of letters and any additional information.****

2. *If your request cannot be resolved, you will be invited to the Grievance Committee. You and/or your representative can participate in person or by telephone before the Grievance Committee to give written or oral information. You may give written questions to the person or persons responsible for making the decision. You, your provider or the facility rending service may submit additional information for consideration. Health Tradition takes all additional information submitted into account whether or not that information was part of the initial consideration of your case. We will give you seven (7) days notice of the date, time and location of the meeting. We will make special accommodations for you if you need them, including interpreter services.*

3. ***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.***

4. Do you need any special arrangements? o yes o no

   Please describe any special needs:

Signature_____

HealthTradition
Health Plan
WITH MAYO CLINIC HEALTH SYSTEM

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 or experimental treatment **AND** the care cost $295 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 your 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.