**REQUEST FOR AN APPEAL – CHIP Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Driscoll Health Plan Texas Department of Insurance Utilization Review Agent Licensure #1784904

Thank you for providing us with your appeal request. You may complete your appeal orally or in writing. You do not have to return this form for us to process your appeal. If you complete this form, it will help us to work on your request.

**Name of the Person Requesting the Appeal** (Print)

(Last Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(M.I.)\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (area code) (number)

Relationship to the Member: (Please check one)

( ) Legally Authorized Representative ( ) Family Member ( ) Friend ( ) Provider ( ) Attorney

( ) Provider of Record ( ) Member

**Member Information:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: / / Phone: ( ) -

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Information** (*Please provide information about the doctor or other health care provider that has primary responsibility for the care, treatment, and services rendered to the member):*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) - Fax: ( ) -

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

**Information regarding the Appeal:**

Original Date of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Denial: \_\_\_\_/\_\_\_\_/\_\_\_\_ Referral Number: \_\_\_\_\_\_\_\_

Reason for appeal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Please submit any additional documentation that you would like considered with this appeal***

***Please return this form to*:** Driscoll Health Plan

 Quality Management Department

 Attn: Member Appeals Team

 4525 Ayers Street

 Corpus Christi, Texas 78415

 Fax Number: 361-808-2186

If you have any questions concerning the appeal process, please feel free to call us at 1-877-324-7543.

A member advocate will help you with the process.