Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

# APPEAL FORM

If you disagree with our decision not to approve the service your doctor asked for, you can file an appeal using this form within 60 days from the date of your denial letter.

Your provider, or any other person you choose, may appeal for you. If you ask someone to represent you, please give them a signed letter of consent to include with the appeal.

**MEMBER INFORMATION:**

| Member's name: | Anthem HealthKeepers Plus ID: | | Date of birth: |
|---|---|---|---|
| Address: | City: | State: | ZIP code: |

**TYPE OF APPEAL REQUEST: _____Standard _____Urgent**

An appeal may be handled urgently if you, your representative or your provider thinks:

- The condition could seriously harm your life, health or ability to regain full function.
- Would subject you to severe pain that can't be managed without care or treatment by waiting for the appeal to be resolved using standard appeal time frames.

PERSON MAKING APPEAL REQUEST: _____Member _____Provider _____Other

**CONTACT INFORMATION:**

Name of person requesting appeal for the member:
_____

Phone number: _____ Fax number: _____

Email: _____

**Requestor's relationship to member:**

_____ Member/parent or legal guardian asking for appeal
_____ Member's representative asking for appeal for the member (must have member consent)
_____ Provider asking for appeal for the member (must have member consent)

**APPEAL DETAILS:**

Name of servicing provider: _____

Type of service or item to be given: _____

Authorization reference number (if known):_____

Date of service: _____ Service Type: Inpatient ☐ Outpatient ☐

**Tell us why you think HealthKeepers, Inc. should cover this service or item.**

_____
_____
_____
_____
_____

**Attach any documents that support your appeal.**

☐ Yes, I attached medical records/documents Number of pages attached: _____
☐ No, I didn't attach medical records/documents

**Requestor's Signature: _____ Date: _____**

**Mail this form and any relevant documents to:**

**Central Appeals Processing**
**HealthKeepers, Inc.**
**P.O. Box 62429**
**Virginia Beach, VA 23466-2429**

Call toll free for translation or oral interpretation at no cost/Llame a la línea gratuita para servicios de traducción o interpretación sin cargo: 1-800-901-0020 (Medallion Medicaid, FAMIS); 1-855-323-4687 (CCC Plus); TTY 711.

**www.anthem.com/vamedicaid**