TOTAL HEALTH CARE

TOTALLY THERE FOR YOU

Appeal Form

SECTION 1: MEMBER INFORMATION

Member Name	Contract Number		
Address	City	State	ZIP
Home Phone / Hours Available	Work Phone / Hours Available		
Person Asking for Appeal	Relationship to Member		
Name(s) of Provider(s) Involved			

SECTION 2: APPOINTMENT OF REPRESENTATIVE

Part 1: To Be Completed by the Member

I appoint the following individual, _____, to act as my representative in requesting an appeal regarding the adverse determination outlined below. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that I must complete the enclosed Authorization for Release of Personal and Health Information form to allow disclosure of my personal medical and behavioral health information to my authorized representative.

Member Signature: _____ Date: _____

Part 2: To Be Completed by the Representative

_____ , hereby accept the above appointment.

Representative Signature: _____ Date: _____

Representative Address	Phone Number

SECTION 3: APPEAL INFORMATION

1. Under what section of Total Health Care Certificate of Coverage (COC) do you believe this service would be covered?

2. What new facts not previously mentioned would you like considered in this appeal?

Continued >

3. What action are you asking Total Health Care to take and why?

SECTION 4: ACKNOWLEDGEMENT

By submitting this appeal, I understand that Total Health Care will complete a thorough investigation of my appeal for review by the Appeal Committee. I understand that this may involve contacting appropriate providers to gather relevant medical records including photos, claims information relating to diagnosis, prognosis and treatment for physical and mental illness, mental health, substance abuse, communicable diseases, serious communicable diseases and infections, and other conditions, ailments, sicknesses and diseases, including human immunodeficiency virus (HIV) infections and acquired immunodeficiency syndrome (AIDS).

Signature (Member, Parent/Legal Guardian if Member is under 18 years of age, or Authorized Representative) Date:

SECTION 5: CONFIDENTIALITY

Total Health Care is committed to maintaining the confidentiality of the information that you send to us. The attached form must be completed and submitted with your appeal form if:

- You would like Total Health Care to disclose any information regarding your appeal to someone other than yourself, such as your spouse, a family member, your authorized representative, or any other third party.
- You are a parent submitting the appeal on behalf of your dependent child when the dependent child is 18 years of age or older.
- You are a parent submitting the appeal on behalf of your dependent child when the dependent child is 14 years of age or older and your appeal involves substance abuse or behavioral health treatment.

Return completed form to:
Total Health Care
3011 W. Grand Blvd., Suite 1600
Appeals Department
Detroit, MI 48202