Member Appeal Form

Complete and mail or fax to:
Allwell from Buckeye Health Plan | Attention: Appeals & Grievances/Medicare Operations 7700 Forsyth Blvd | Saint Louis, MO | 63105 | Fax: 1-844-273-2671

As a member of Allwell from Buckeye Health Plan you have the right to file an appeal for any denials related to medical services (Part C) or prescription drug (Part D) coverage. All **standard** appeal requests must be filed in writing. You may file **expedited*** appeal requests in writing or by calling Member Services at 1-866-389-7690 (TTY/TDD: 711). From October 1 through March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends, and on Federal holidays. Allwell from Buckeye Health Plan will give you a decision within the following timeframes from receiving your request:

Standard Medical Pre-Service Appeals: **30 calendar days**
Standard Prescription Drug Related Appeals: **7 days**
Expedited Medical Pre-Service Appeals: **72 hours**
Expedited Prescription Drug Related Appeals: **72 hours**

Appeals related to payment issues will be given a standard appeal decision within 60 calendar days of request receipt. If we need more information and the delay is in your best interest or if you ask for more time, we have up to 14 more calendar days. We will tell you or your representative in writing if we decide to take extra days to make the decision.

****Expedited appeals** mean you feel that using the standard deadlines could cause serious harm to your life or health or jeopardize your ability to regain maximum function. You must also be asking for coverage for medical care or a drug you have not yet received.*

Member's Name: Last_____First_____

Medicare ID Number: _____

Member Date of Birth:_____

Relationship to Member* (please choose one): ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other:_____

**If other than "Self" is selected, required proof of guardianship, power of attorney or an Appointment of Representative (AOR) form will be required. The AOR form can be found on our Resources/Materials website tab.*

Name of Person Submitting the Appeal: _____

Phone Number(s): Home:_____Cell:_____

Street Address:_____

City:_____State:_____Zip:_____County:_____

Physician: _____

Appeal Type (please choose one):
□ Standard Pre-Service (Medical) Appeal – (30 day review) □ Expedited Pre-Service (Medical) Appeal – (72 hour review)
□ Standard Part D (Prescription Drug) Appeal – (7 day review)
□ Expedited Part D (Prescription Drug) Appeal – (72 hour review)
□ Standard Payment Issues Appeal – (60 day review)

What was denied? (Please include a copy of the denial letter.)

_____
_____
_____
_____
_____

Why do you think you should have this medical services/prescription or payment?

_____
_____
_____
_____
_____

What is the best way to reach you regarding this appeal? (please choose one): □ Phone □ Email □ Other: _____
Signature of Person Appealing:_____Date: _____

Allwell *is contracted with Medicare to offer HMO, HMO SNP and PPO plans and with some Medicaid programs. Enrollment in Allwell depends on contract renewal. This information is available for free in other languages. Please call our Member Services number at 1-866-389-7690 [TTY: 711]*. From October 1 through March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends, and on Federal holidays.

For Administrative Use Only
*Appeal Number:*_____*Date Received:*_____