ProCare Rx

First Level
Internal Appeal Request Form

Please keep copies of this form, your Adverse Benefit Determination and all documents/correspondence related to this claim.

A. General Information

Date:	Name: *(person filing appeal)*

Relationship to Covered Person:

☐ Member/Applicant ☐ Authorized Representative *(please complete the Appointment of Authorized Representative section)*

How would you like us to contact you? ☐ Phone ☐ Fax ☐ Email ☐ Mail

B. Member/Applicant Information

Name:			ID #:
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Fax:	Email:

C. Authorized Representative Information *(if applicable)*

Name:			
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Fax:	Email:

D. Treating Physician/Healthcare Provider Information

Name:	Contact Person:		
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	

E. Internal Appeal Specifications:

1. Are you requesting an expedited appeal because your health, life, or ability to regain maximum function may be in serious jeopardy while you wait up to 30 days for a decision on your appeal: ☐ YES ☐ NO
2. Are you requesting an expedited appeal because your physician certifies that your pain cannot be controlled while you wait up to 30 days for a decision on your appeal? ☐ YES ☐ NO
3. Are you requesting a Concurrent Internal Appeal and/or Expedited External Review and your physician certifies it necessary? *(Note: Request for External Review is not required.)* ☐ YES ☐ NO

* *If you answer YES to Questions 2 or 3 above, your physician must complete the Treating Physician Certification Form for Internal Appeal and/or External Review. You may also have your physician complete The Certification Form if you answer YES to Question 1.*

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim).

F. Appointment of Authorized Representative *(Complete when someone else is representing you in this appeal)*

You may represent yourself or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Member or Legal Representative:	Date:

Please send this form and a copy of your Notice of Adverse Benefit Determination to one of the following:

Toll Free Fax: 1-866-965-3784 **OR** 1-866-999-7736 | Email: appeals@procarerx.com
Mail: ProCare Rx Pharmacy Care, 2850 North Commerce Pkwy, Miramar, FL 33025