

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

A. General Information				
Date:		Name: <i>(person filing appeal)</i>		
Relationship to Covered Person: Member/Applicant Authorized Representative <i>(please complete the Appointment of Authorized Representative section)</i>				
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 <i>(if applicable)</i>				
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? <i>(Note: Request for External Review is not required.)</i>			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 <i>(Complete when someone else is representing you in this appeal)</i>				
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