FirstCare HEALTH PLANS

NOTICE OF APPEAL REQUEST FORM

Date: _____

Name of Person Requesting the Appeal (Print)

_____

(Last Name) (First Name) (M.I.)

Phone Number: _____ _____
(area code) (number)

Relationship to the Member: *(check one)*

☐ Self
☐ Provider
☐ Person acting on behalf of Member

Relationship:_____

Member Contact Information:

Member ID Number _____

Name _____ Date of Birth: _____ _____

Address _____ City _____ State _____ Zip Code _____

Phone Number: _____ _____
(area code) (number)

Provider Information: *Please provide information about the physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the member.*

Name _____

Address _____ City _____ State _____ Zip Code _____

Phone Number: _____ _____ Fax Number: _____ _____ *(if applicable)*
(area code) (number) (area code) (number)

Information Regarding the Appeal:

Original Date of Service: _____ Date of Denial: _____

Reason for Appeal _____

_____

Please submit any additional documentation that you would like considered with this appeal.

RELEASE OF INFORMATION

(Signature is required for an appeal of a notice if submitted by the provider on behalf of the member)

I, _____ , the member, or his/her legal guardian, do hereby authorize the release of all
(print name)
necessary medical records and other documents that are relevant to this review.

_____
(signature)

RETURN THIS FORM TO:
FirstCare Health Plans
Attn: Appeals Department
12940 N. Hwy 183
Austin, TX 78750
FAX: 1-806-784-4319