Appeal Request Form

If you have a complaint or grievance, please complete and submit this form to Oklahoma Complete Health to start the appeals process. The completed form must be received by Oklahoma Complete Health **within sixty (60) days of the triggering event.** This is the date on which the event you are appealing occurred.

Failure to complete and return this form within sixty (60) days can result in dismissal or denial of your appeal.

Please provide all requested information, including a complete explanation of the problem/issue. Include the name(s) of any Oklahoma Complete Health people you have dealt with, and the dates on which specific events occurred. Use more paper if necessary. Attach copies of any supporting documents you would like to be considered.

Member Information

Member Name: _____ Member ID: _____

Member Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

_____

Date of Triggering Event: _____

Member's Guardian (if applicable): _____ Guardian Phone: _____

Authorized Representative (if any)

I, _____authorize _____to serve as my representative in connection with the appeal. I authorize my representative to present evidence, to obtain information about my appeal, and to receive notices in connection with my appeal. I understand that my personal health information (PHI) may be disclosed to my representative. I understand that my PHI may include information about drug or alcohol disorders or treatment, mental health disorders or treatment, and communicable or non-communicable diseases. By signing this form, I am authorizing disclosures of this information. My representative will be available to represent me on the date and time of the appeal hearing as set by Oklahoma Complete Health. I do not have a legally appointed guardian, or my legally appointed guardian hereby consents to this authorization.

_____

Member Signature Date

_____

Authorized Representative Signature Date

Mailing Address: _____

Phone Number: _____

Email Address: _____

Please tell us about your request in the space below. Be as specific as possible and when possible, give the date(s) that the event occurred. Please include what you would like Oklahoma Complete Health **to do about this issue.** *(If you need more space, use another sheet of paper.)*

IMPORTANT NOTICE FOR MEMBERS OF SOONERSELECT BENEFITS OR SERVICES WHOSE BENEFITS OR SERVICES WERE DISCONTINUED OR REDUCED:

You must request an appeal and your appeal must be received by Oklahoma Complete Health. Your appeal must be filed within sixty (60) calendar days of the date of your notice. You can ask for your services to continue while your appeal is reviewed. You must ask for services to be continued within ten (10) calendar days of the date of your notice. You can also ask for your services to stop while your appeal is reviewed. If you file for an appeal within 60 calendar days of the date of your notice and do not ask for your services to stop, they will be continued during the review period. When your appeal doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.

If you do **NOT** want services or benefits to continue while your appeal is pending, check the box below:

☐ I **do not** want services or benefits to continue while my appeal is being decided.

_____ _____

Member Signature ***Date***

Please send this form to:

Oklahoma Complete Health
Attn to Appeals and Grievances
PO Box 10353
Van Nuys, CA 91410-0353

Phone: 1-833-752-1664
Email: OKCompleteHealth_Appeals@CENTENE.COM