Molina Healthcare of Idaho Medical Appeal Request

If you want to appeal the decision we have made, you must fill out the form and send it to us within 60 calendar days of the date on the Notice of Action. You can also call us within 60 calendar days of the Notice of Action.

If your health care provider thinks your life or health is in immediate danger because of the decision in the Notice of Action, he/she can ask for an expedited appeal by either calling us or sending us this form.

If you want help completing this form, please call (844) 809-8445 (TTY:711).

Is the member or a health care provider requesting this appeal? ❑ Member ❑ Provider

Date: _____

Member last name: _____ Member ID: _____

Member first name: _____Member middle initial: _____

Current address: _____Apt. if app: _____

City: _____State: _____Zip: _____

Phone number: _____

Doctor's name: _____

What kind of an appeal is this? Please check one:

- ❑ **Standard**
- ❑ **Expedited** - If your provider thinks your life or health is in immediate danger, you may ask for an expedited (quick) appeal decision.
- ❑ **Continuation of Benefits** - <u>You can only ask that you keep getting services</u> if Molina has terminated, suspended, or reduced a service that Molina had previously authorized. You must request continuation of those services within 10 days of this Notice of Action. It also means that you may have to pay Molina for these services if the appeal decision is to deny the services.

What results are you hoping for from this appeal?

_____

_____

_____

Please attach any information that will help us understand your medical case and your appeal, and send to:

Molina Healthcare of Idaho
Attn: Grievance and Appeals Department
7050 South Union Park Center Suite 600
Midvale, UT. 84047
Fax: 877-682-2218