Molina Healthcare of New York, Inc.

Appeal request form

For services being reduced, suspended, or stopped

Mail to:
Molina Healthcare of New York, Inc.
1776 Eastchester Road
Bronx, NY 10461

Fax to (315) 234-9812

Today's date:_____

Deadline:

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. (If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is [Date+10].**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is [DATE+60]. If you want a Plan Appeal, you must ask for it on time.**

Enrollee information:

Name: [First Name] [Last Name]
Enrollee ID: [Enrollee ID]
Address: [Address] [City , State Zip]
Home Phone: [ ] Cell Phone: [ ]
Plan Reference Number: [Reference Number]
Service being reduced, suspended or stopped: [SERVICE]

I think the plan's decision is wrong because:

_____

_____

_____

_____

_____

_____

MOLINA® HEALTHCARE

Check all that apply:

- ☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.
- ☐ I request a Fast Track Appeal because a delay could harm my health.
- ☐ I enclosed additional documents for review during the appeal.
- ☐ I would like to give information in person.
- ☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with Molina before?
    YES ☐ NO ☐
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind.
    YES ☐ NO ☐

Requester (person asking for me):

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: ( )_____Fax #: ( )_____

Enrollee signature: _____ Date:_____

Requester signature: _____ Date:_____

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

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