MotivHealth
PO Box 709718
Sandy, UT 84070-9718
Customer Service 844-234-4472

# Customer Appeal Request Form

As a member of MotivHealth, you have the right to appeal a previous decision made regarding your medical health insurance benefits. Your appeal, can be conveniently completed and evaluated by us in the following ways.

**Option 1: Contact a member of our Personal Health Assistant Team**

In many cases, we may be able to resolve your issue(s) efficiently outside of the formal appeals process. Should our Personal Health Assistant Team not resolve your matter, please know you will be informed on how to exercise your right to request a more official appeal.

**Option 2: Complete this Customer Appeal Request Form**

Complete and mail this form with the information requested to the address listed above. To ensure your appeal is processed efficiently, please complete the applicable documentation as accurately and timely as possible.

**Your appeal should be submitted within 180 days. Once received, MotivHealth will process your request and perform a thorough review of the information presented and its relevance to your current medical coverage.**

**Please Provide the Following Regarding Your Appeal**:

- A completed MotivHealth"Customer Appeal Request Form"
- A copy of your explanation of payment (EOP), explanation of benefits (EOB) or our initial adverse letter if applicable
- Any supportive documentation that may support your appeal. If your denial was based on a lack of medical necessity, please provide any additional documentation or medical records you might have, including any statements provided by licensed health care provider(s) or facility(s) describing the services and/or treatments received.

| **Subscribers Information** | | | |
|---|---|---|---|
| Members Full Name | | | Members Date of Birth |
| Members Address | City | State | Zip Code |
| Members ID Number | Members Group Number | | |
| Physician or Medical Facility Name | | | Date of Service |
| Procedure/Type of Service | | | Claim Number |

Appeal Completed By:
☐ Member ☐ Primary Care Physician ☐ Specialist/Ancillary Physician ☐ Medical Facility/Hospital

☐ Other: _____

Name _____ Phone _____

Signature _____ Date _____

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**Reason for Your Appeal**

- ☐ Medical Necessity
- ☐ Timely Claim Filing
- ☐ Coverage Exclusion or Limitation
- ☐ Request for In-Network Coverage
- ☐ Maximum Reimbursement Amount
- ☐ Inpatient Facility Denial
- ☐ Incidental Procedure Code Denial
- ☐ Additional Reimbursement
- ☐ Experimental and/or Investigative Procedure
- ☐ Benefits Reduced Due to Repricing

**Please explain why you feel our original coverage decision was inappropriate and what you would like to see happen because of this appeal.**

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**Additional Comments:**

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**We request your permission to authorize MotivHealth to request any medical records needed to answer your appeal. This includes any information pertaining to alcohol or drug abuse, mental health, AIDS or HIV virus, if applicable. This authorization begins today and will remain in force for as long as the appeal process exists.**

X _____ Date: _____

(Signature of Patient or Authorized Representative)