



Member Appeal Form

Complete and mail or fax to:

Allwell from PA Health and Wellness | Attention: Appeals & Grievances/Medicare Operations
7700 Forsyth Blvd | Saint Louis, MO | 63105 | Fax: 1-844-273-2671

As a member of Allwell from PA Health and Wellness you have the right to file an appeal for any denials related to medical services (Part C) or prescription drug (Part D) coverage. All **standard** appeal requests must be filed in writing. You may file **expedited*** appeal requests in writing or by calling Member Services at 1-855-330-9368 for (HMO SNP) and 1-855-766-1456 for (HMO) (TTY/TDD: 711). From October 1 through March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends, and on Federal holidays. Allwell from PA Health and Wellness will give you a decision within the following timeframes from receiving your request:

Standard Medical Pre-Service Appeals: **30 calendar days**

Standard Prescription Drug Related Appeals: **7 days**

Expedited Medical Pre-Service Appeals: **72 hours**

Expedited Prescription Drug Related Appeals: **72 hours**

Appeals related to payment issues will be given a standard appeal decision within 60 calendar days of request receipt. If we need more information and the delay is in your best interest or if you ask for more time, we have up to 14 more calendar days. We will tell you or your representative in writing if we decide to take extra days to make the decision.

**Expedited appeals mean you feel that using the standard deadlines could cause serious harm to your life or health or jeopardize your ability to regain maximum function. You must also be asking for coverage for medical care or a drug you have not yet received.*

Member’s Name: Last _____ First _____

Medicare ID Number: _____

Member Date of Birth: _____

Relationship to Member* (please choose one): Self Parent Legal Guardian Spouse

Other: _____

**If other than “Self” is selected, required proof of guardianship, power of attorney or an Appointment of Representative (AOR) form will be required. The AOR form can be found on our Resources/Materials website tab.*

Name of Person Submitting the Appeal: _____

Phone Number(s): Home: _____ Cell: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Physician: _____

Appeal Type (please choose one):

- Standard Pre-Service (Medical) Appeal – (30 day review) Expedited Pre-Service (Medical) Appeal – (72 hour review)
- Standard Part D (Prescription Drug) Appeal – (7 day review)
- Expedited Part D (Prescription Drug) Appeal – (72 hour review)
- Standard Payment Issues Appeal – (60 day review)

What was denied? (Please include a copy of the denial letter.)

Why do you think you should have this medical services/prescription or payment?

What is the best way to reach you regarding this appeal? (please choose one): Phone Email

Other: _____

Signature of Person Appealing: _____ Date: _____

Allwell is contracted with Medicare to offer HMO, HMO SNP and PPO plans and with some Medicaid programs. Enrollment in Allwell depends on contract renewal. This information is available for free in other languages. Please call our Member Services number at 1-855-330-9368 for HMO SNP and 1- 855-766-1456 for HMO [TTY: 711]. From October 1 through March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends, and on Federal holidays.

For Administrative Use Only

Appeal Number: _____ *Date Received:* _____