Appeal request form

Please complete this form and return it to us. Make sure that you have **signed** and **dated** the form. For help with this form, please call Customer Service, Monday through Friday, 8 a.m. to 8 p.m.

- In Corvallis at **541-768-4550**.
- Toll free at **800-832-4580**.
- TTY users call **800-735-2900**.

Which health plan do you have? (check one box):

☐ IHN-CCO ☐ Samaritan Choice ☐ Samaritan Employer Group Plans

Member information

This should be the person whose name is on the denial letter, bill or explanation of benefits (also called an EOB):

First name: _____ Last name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Member ID: _____ Phone: _____

What decision do you want us to change?

Note: You may attach papers to this form to help explain your request. For example, you may want to include:

- A letter from your doctor or a copy of your medical records.
- Bills or EOB that you have received.
- The denial letter.

Turn page over to finish the form ▶▶▶

Why do you think we should change the decision?

Please use a blank page if you need more space.

Important notice for IHN-CCO members:

If you are already receiving the service we denied, you can continue to receive the service if you send us this form **within 10 days of the date on your denial letter**. You may have to pay for the service you are receiving if we deny your appeal.

Check this box if you want to continue to receive the service we denied. ☐

You can ask us to make a fast (expedited) decision on your appeal.

You can ask us to decide faster than usual if:

1. You think your health or mental health may be in serious danger.
2. Your doctor says that waiting the usual amount of time for us to decide (see your plan's Evidence of Coverage) would put your life in serious danger.
3. Your doctor says you have pain that cannot be controlled.

Check this box if you want a fast decision on your appeal. ☐

Sign and date this form.

If you have not signed and dated this form, we will not process your request.

If this request is for a child who is 15 years old or younger (14 years old or younger for mental health services and 13 years old or younger for reproductive health), their parent or legal guardian must sign.

Signature: _____ Date: _____

Relationship to member:
- ☐ Self.
- ☐ Provider appealing for member. (You must have written permission from the member to appeal.)
- ☐ Authorized Representative (example: friend or relative of member).

You can email, fax, mail or hand deliver this form.

- **Email to:** SHPOAppealsTeam@samhealth.org.
- **Fax to:** 541-768-9765.
- **Mail to:** Samaritan Health Plans Operations – Appeals Team, PO Box 1310, Corvallis, OR 97339.
- **Hand deliver to:** 2300 NW Walnut Blvd, Corvallis, OR 97330.

Important: Keep copies of this form and all other papers that have to do with this request.