Appeal request form

Samaritan Health Plans

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**.

This form is for Samaritan Advantage members only.

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.

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 appeal 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.

☐ Treating provider/prescriber: pre-service only, contracted and non-contracted (no documentation required).

☐ Treating provider/prescriber appealing for member (supporting documentation required).

☐ Treating provider/prescriber (contracted) appealing denied payment (CMS form 1696 required).

☐ Treating provider/prescriber (non-contracted) appealing denied payment (Waiver of Liability required).

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

- **Email to:** SHPOAppealsTeam@samhealth.org.
- **Fax to:** 541-768-9765.
- **Mail to:** Samaritan Advantage Health Plans – 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.