Southcoast® Health Network

PATIENT CARE APPEAL

PLEASE PRINT

A. Member Name: ______________________________
LAST FIRST MIDDLE

Home Address: ______________________________

Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ **Date of Birth:** ☐☐ ☐☐ ☐☐☐☐
M M D D Y Y Y Y

Member Insurance Plan: ____________ **Policy ID Number:** ____________

Provider's Name: ____________ **Today's Date:** ____________

Provider's Address: ______________________________

B. Please tell us what you are appealing:

- ☐ Denial or restriction of a referral
- ☐ Denial or restriction on the type or intensity of treatment
- ☐ Denial or restriction on timely access to treatment or services
- ☐ Other Care - Related Concern

C. Using the back of this form please provide a description of your appeal

D. This section only applies if a personal representative is named. I affirm that I am the member or the parent/ legal guardian of the member named in **A** above. I hereby appoint the individual named below to act as Personal Representative for the limited purpose of appealing the denial or restriction of coverage described in **C** below, and I authorize Southcoast Health Network to release Protected Health Information related to these claims to the Personal Representative named herein:

______________________________ ____________

Signature of Member (or Member's parent/legal guardian) **Date**

Name of Personal Representative: ______________________________
LAST FIRST

Relationship to Member: ______________________________

Address: ______________________________

Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ **Age:** ☐☐

I hereby agree to serve as the above-mentioned member's Personal Representative acting on their behalf for the purposes of appealing the denial of coverage as described below.

______________________________ ____________

Signature of Personal Representative **Date**

E. Please return this form to:

PATIENT EXPERIENCE DEPARTMENT
101 Page St. New Bedford, MA 02740
Secure Fax: 508-973-2176
Email: appeal@southcoast.org

QUESTIONS?
Please call 508-973-2174

☐ Please check if this is an urgent medical need such as a terminal illness or an emergency situation.

Description of Appeal

____

____

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Signature: ____

Print Name: ____