Alliance Coal Health Plan

# Appeal Request Form

If you are not satisfied with the initial attempt to resolve your problem or if you wish to request a review of a benefit determination, preauthorization decision, or a rescission of coverage, you must request an appeal within 180 days from the date you received notice of the adverse benefit determination or preauthorization notice.

As a part of the appeals process, you have the right to be provided, upon request and free of charge, reasonable access to or copies of all documents, records, and other information relevant to the claim. The appeal process will include all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Please complete all fields as requested. Incomplete forms received may cause delay in processing. Mail completed form and any pertinent documentation, including medical records not previously submitted, that you want to become part of this review to:

Alliance Coal Health Plan
Attn: Appeals
PO Box 1950
Tulsa, OK 74101-1950

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|---|---|---|
| Date | Name of Requestor | Member Name |
| Phone | Member ACZ# | Relationship to Member |
| Date of Service | Name of Provider | Place of Service or Hospitalization |
| Type of Service or Procedures Received (if applicable) | | Claim # |
| Use this space (and attach additional sheets if necessary) to explain why the claim denial decision should be reversed | | |

☐ Please check this box if additional medical records that support your appeal are included