Alliance Coal Health Plan

Appeal Request Form for Medications

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. Incomplete forms received will be rejected. Mail or fax completed form and any pertinent documentation, including additional medical records and lab results to:

Alliance Coal Health Plan
Attn: Appeals
PO Box 1950
Tulsa, OK 74101-1950
FAX: 844-230-8727

Today's Date	Name of Requestor Relationship to member: member/spouse/parent/provider	Requestor's Phone #
Member Name	Member ACZ#	Name of Prescriber
Prescriber's Phone #	Prescriber's Fax #	Diagnosis
Medication requested with dosage, route, and frequency		
Use this space (and attach additional sheets if necessary) to explain why the claim denial decision should be reversed. If you are requesting a Plan exception because the medication is excluded from the Plan formulary, you must include the names of formulary medications that have been tried, dates they were tried and the date and reason why they were discontinued. You should also attach the MD's office visit notes (preferably the last three visit notes) and related lab results.		