



1605 Associates Drive  
Suite 101  
Dubuque, IA 52002

## Appeal Form

This form is to be completed by you, as a covered Member, or your Authorized Representative (if you have designated one), if you disagree with a benefit determination and request a review of a claim for benefits that has been denied.

### Member Information

Member Name	Member ID#	Date of Birth
Mailing Address		
Phone Number	Email Address	Subscriber Name ( <i>if different from member</i> )

### Legal Guardian / Legal Representative / Authorized Personal Representative

\* If you are requesting an appeal on behalf of a Member, you must be the Member's legal guardian or legal representative, or an Appointment of Authorized Personal Representative Form must be submitted with this form or already on file with Medical Associates Health Plans. A Member may appoint only one Authorized Personal Representative at a time.

This appeal is being requested by (Insert Full Name)	Relationship to Member
Mailing Address	Phone Number

### Claim Information (This information may be found on the front of your Explanation of Benefits or letter of denial.)

Has the service in question already been provided?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of Service(s):	Date of Denial:
Provider Name:	Provider Name:
Claim Number(s):	

Please include an explanation of your appeal and a statement of the action you would like taken in response to your appeal. Attach any and all documentation (written comments, records, or other documents) that may support your appeal. **This appeal must be filed within 180 days of the date on the Explanation of Benefits or letter of denial of coverage.** You will receive a written response within the time required by law. For more information, consult your Subscriber Agreement, or contact Member Services at 563-584-4885, or toll free at 866-821-1365, or by email to [MemberServices@mahealthcare.com](mailto:MemberServices@mahealthcare.com).

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Are there documents attached?  Yes  No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### Return completed form to:

Medical Associates Health Plan, Inc.  
1605 Associates Drive, Suite 101  
Dubuque, IA 52002

Fax: 563-556-5134

Email: [MemberServices@mahealthcare.com](mailto:MemberServices@mahealthcare.com)

Retain for your records a copy of this form and any additional documentation submitted in support of your appeal.