KENTUCKY HEALTH COOPERATIVE

PHARMACY APPEAL REQUEST FORM

APPEALS PHONE: 1-855-635-5580 OPTION 4
APPEALS FAX: 1-502-638-2543

Name of person filing appeal:_____

Relationship to covered person: ❒Covered Person/Applicant

❒Authorized Representative ***(please complete the Appointment of Authorized Representative section)***

How would you like us to contact you? ❒Phone ❒Fax ❒Email ❒Mail

Contact information of authorized representative (if applicable):

Mailing Address:_____

Daytime Phone:_____ Evening Phone:_____

Email Address:_____ Fax:_____

Covered Person/Applicant Information:

Name:_____ ID Number:_____

Mailing Address:_____

Daytime Phone:_____ Evening Phone:_____

Email Address:_____ Fax:_____

Treating Physician/Health Care Provider Information:

Name:_____

Mailing Address:_____ Phone Number:_____

Email Address:_____ Fax Number:_____

Contact Person:_____ Phone Number:_____

Internal Appeal Specifications

1. Are you requesting an expedited appeal because your health, life or ability to regain maximum function may be in serious jeopardy while you wait up to 30 days for a decision on your appeal? ❒YES ❒NO
2. Are you requesting an expedited appeal because your physician certifies that your pain can not be controlled while you wait up to 30 days for a decision on your appeal? ❒YES* ❒NO
3. Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review and your physician certifies that it is necessary? *(Note: Request for External Review form is not required.)* ❒YES* ❒NO

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*If you answer YES to question 2 or 3 above, your physician must complete the Treating Physician Certification Form for Internal Appeal and/or External Review. You may also have your physician complete the certification form if you answer YES to question 1.

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____

Signature of Covered Person (or legal representative**) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I _____ hereby request an appeal. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, health care provider, and/or health plan issuer to release all relevant medical or treatment records to an independent review organization, the Kentucky Department of Insurance, and/or my health plan issuer. I understand that the independent review organization, the Kentucky Department of Insurance, and/or my health plan issuer will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____

Signature of Covered Person (or legal representative**) Date

***Parent, Guardian, Conservator or Other - please specify*

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Statement of Medical Necessity (reason for appeal):

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter that includes information not included in original request, i.e. other medications tried/failed, additional/clarified diagnosis, bills, medical records, or other documents to support your claim):

_____

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SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING:

Appeals Fax Number: 1-502-638-2543 Appeals Phone: 1-855-635-5580 option 4

Mailing Address:

Kentucky Health Cooperative
Grievance and Appeal Department
9700 Ormsby Station Road, Suite 100
Louisville, KY 40223

Be certain to keep copies of this form, your Notice of Adverse Benefit Determination and all documents and correspondence related to this claim.