

Medical Appeal Form

If you disagree with our decision to deny a claim or reduce medical benefits, use this form to request reconsideration. You are invited and encouraged to attach any documentation that supports your appeal, such as medical records, bills and notes from doctors. For pharmacy benefit denials or reductions, please use the **Pharmacy Appeal Form**.

Member Information

First Name:		Last Name:	
Member ID:	DOB:	Claim or Auth #:	
Street Address:		Dates of Service:	
City:		Phone:	
State:	Zip:	Email (optional):	
Preferred method of contact regarding this appeal: ☐ Phone ☐ Email ☐ Mail		Is this appeal expedited/urgent? ☐ Yes ☐ No Expedited appeals are only available for services that have not yet been rendered.	

Person Completing this Form (if different from member)

First Name:		Last Name:	
Relationship to Member: ☐ Friend ☐ Family ☐ Authorized Representative ☐ Other			
Phone:		Email:	

Appeal Information

Why are you filing an appeal?

What is your desired outcome with this appeal?

Consent

By signing below, I give St. Luke's Health Plan, Inc. permission to investigate this appeal, review associated medical records, and talk to my healthcare provider(s) about my appeal.

Member Signature*:

**Or the signature of the person authorized to act on your behalf under Idaho state law. If this form is signed by an authorized representative, this signature certifies that:*

- 1. This person is authorized under Idaho state law to act on the member's behalf; and*
- 2. Documentation of this authority is available upon request by St. Luke's Health Plan, Inc. or the Centers for Medicare and Medicaid Services (CMS).*

Questions?

If you have any questions about this form, please call Customer Service at **833-840-1214 (TTY: 711)**.

We are available October 1 to March 31, seven days a week, from 8 a.m. to 8 p.m. and April 1 to September 30, Monday to Friday from 8 a.m. to 8 p.m.

Send this completed form and any documentation you want to provide via email or mail:

Mail:

St. Luke's Health Plan
Attn: Appeals Department
PO Box 1739
Boise, ID 83702

Email: slplanappeals@slhealthplan.org