

APPEAL FORM

Instructions:

In order for us to process your clinical appeal, please complete and sign this form. If the form is completed by the Provider, we must receive written confirmation that Provider is acting on behalf of member. Please include the signed, written permission by Member. This form may be mailed to Sheree Marzka or faxed to 785-338-9020. Upon receipt of the completed form, Value Options will investigate your appeal and notify you of a resolution within 14 days of receiving all requested information.

By filling out and signing the attached authorization for use or disclosure of medical information form, you are also authorizing ValueOptions to obtain any medical records applicable to your appeal.

MEMBER NAME: _____

VALUEOPTIONS ID#: _____

Date of Treatment: _____

Provider/Facility: _____

Explanation of issues (please give dates, names and attach additional sheets as necessary)

Your signature _____

Date _____

Public Sector Appeals and Denials Coordinator