22 Health
A Division of Community Care Plan

GRIEVANCE AND APPEAL FORM

Please fill out the appropriate section if you are filing an Appeal (a formal request to reverse a decision related to service denials, reductions, or terminations), or a Grievance concerning any dissatisfaction with any aspect of 22 Health's services or providers, excluding denials. Note: Grievances can be submitted at any time, and resolutions are provided as quickly as the member's health condition requires, but no later than 30 calendar days from receipt of the grievance.

1: TYPE OF APPEAL

☐ **Standard Appeal: Decision will be made within 30 days or less.**

☐ **Expedited Appeal: Decision will be made within 72 hours.**

2: PATIENT/MEMBER INFORMATION

Name _____

ID Number _____ **Date of Birth** _____/_____/_____

Telephone _____

Email Address _____

Preferred Method of Contact ☐ **Telephone** ☐ **Email**

3: PERSON FILLING APPEAL (PROVIDER OR AUTHORIZED REPRESENTATIVE)

Name _____

Relation to Member _____ ☐ **Provider** ☐ **Other**

Describe Other (If Applicable) _____

Specialty *(If Provider)* _____

Clinical Address _____

Zip Code _____ **Email Address** _____

Telephone _____ **Fax** _____

Signature of Person Filing Appeal _____

Date _____/_____/_____

Fax, mail, or email completed forms to:

Community Care Plan | www.ccpcares.org
1643 Harrison Parkway, Bldg. H, Suite 200
Sunrise, FL 33323

Telephone: 1-(866)-357-4082
Fax: 954-251-4848
Email: GAdepartment@22Health.com

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4: AUTHORIZED REPRESENTATIVE SECTION

Name _____

Enrollee/Patient Signature _____

Date _____/_____/_____

IMPORTANT *Enrollee/Patient: Please sign and date above if you give consent or "allow" the above-listed Provider or Authorized Representative to file this appeal on your behalf (If a minor, parent, or guardian signature is required).*

5: SUBJECT OF THE APPEAL

Medication Denial ☐ Yes ☐ No

Medication Name _____

Diagnosis _____

Medication Taken Before? ☐ Yes ☐ No Date _____/_____/_____

Name of Pharmacy where it was previously filled _____

Pharmacy Phone Number _____

Has the patient previously tried and failed to prescribe medications for the condition for which you are requesting this medication? ☐ Yes ☐ No

Medication Name	Dose	Start Date	End Date	Reason for Discontinuation

Additional Information: *Please attach and submit the Patient's most current progress notes, lab notes, discharge summaries, or other documentation to support discontinuing previous therapy with your appeal (if available).*

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Is your appeal regarding an authorization denial or a partial authorization denial?

☐ Yes ☐ No

Authorization # _____

Denial Reason _____

Requested Services _____

Are you filing an Administrative Appeal?
Note: Administrative appeals are appeals for denied services or claims in which the denial is not made based on medical necessity. Please check all that apply:

☐ Benefit Issue ☐ Initial eligibility denial

☐ Claim Denial Due to Recision of Coverage ☐ Other

Reason for appeal: Use this section to explain the reason for your appeal. If you need more space, please e-mail, fax, or mail the Grievances and Appeals department at the following contact information provided at the bottom of this form.

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WHAT IS YOUR GRIEVANCE ABOUT?

Check the box below to tell us what your issue or concern is about:

- ☐ **A billing issue**
- ☐ **A transportation concern**
- ☐ **A service/benefit issue**
- ☐ **A quality of service or care issue with your treating physician/office staff**
- ☐ **Other**

If other, please describe: _____

_____

PROVIDE THE DETAILS BELOW:

Please explain the reason for your grievance and clearly state the outcome you are seeking. Be as specific as possible about what happened on the date(s) of service, including who was involved. List all relevant dates of service, health care providers, and facility names.

You may attach additional pages if needed, along with copies of billing statements, payment receipts, clinical records, or any other supporting documents.

_____

_____

_____

_____

_____

_____

_____

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Please tell us what happened in detail. Be as specific as possible about what occurred on the date of service and who was involved. Include all dates of service, health care provider, and/or facility names. You may attach extra pages if you need more space, copies of billing statements, payment receipts, clinical records, or any other supporting information.

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