DENVER HEALTH MEDICAL PLAN INC.™
Medicare Advantage

MEMBER COMPLAINT AND APPEAL FORM

Completion of this form is voluntary. You or your authorized representative must submit this request within 60 calendar days of event occurence or a denial notification letter. Please attach copies of all documents which may support your request. If this is an urgent request please contact the Grievance & Appeals Department directly at 303-602-2261. This form and any accompanying documents may be mailed or faxed to:

Denver Health Medical Plan
Attn: Grievance and Appeal Department
938 Bannock Street
Denver, CO 80204
Fax: 303-602-2078
www.denverhealthmedicalplan.org

DHMP PLAN TYPE (PLEASE CHECK ONE):

◯ Medicare Choice ◯ Medicare Select

Please provide the following information for the person the complaint or appeal is being submitted:

Name (Last, First, Middle Initial) _____ Member ID # _____

Home Address _____

City, State, Zip Code _____ Telephone # _____

Medical Record # _____ Date of Birth (MM/DD/YY) _____

If other than member listed above, please provide the following information for the person submitting the complaint or appeal. You must include a completed Authorized Representative Form (CMS 1696 Form) with your request. Without this form, we will be unable to process your complaint or appeal. Please note, physicians acting on behalf of their patient are not required to complete the CMS 1696 Form. The CMS 1696 Form can be obtained by visiting our website or calling the telephone number provided above.

Name (Last, First, Middle Initial) _____ Telephone # _____

Mailing Address _____

City, State, Zip Code _____

Relationship to Member: ◯ Spouse ◯ Son/Daughter ◯ Parent/Legal Guardian
◯ Friend/Significant Other ◯ Provider/Physician ◯ Attorney
◯ Other (please specify) _____

****IMPORTANT NOTE:** By selecting the Provider/Physician representation box above, the physician and/or provider is acting on the member's behalf with the member's knowledge and approval.

SECTION A: COMPLAINT: If this is in regards to a complaint, please describe the issue in the box below. If you are filing an appeal, please go to Section B. Include dates of service and staff names if applicable. You may use additional pages if necessary and/or attach supporting documentation.

SECTION B: APPEAL: If you wish to file an appeal to a previously denied service or claim, please provide the information requested below.

Is this in regards to a denied claim? ○ Yes ○ No

If yes, please provide the Claim #: _____

Date(s) of Service: _____

Provider Name: _____

Is this in regards to a denied medical service or treatment? ○ Yes ○ No

If yes, please provide the date of the Denial Letter: _____

Please describe in the space provided below the reason and a brief description of your appeal. You may use additional pages if necessary and/or attach supporting documentation.

_____

Member Signature Date

_____

Authorized Representative Signature Date

If you have any questions or need help completing this form, please contact the DHMP Grievance & Appeals Department at 303-602-2261, 8 a.m. - 5 p.m. Monday through Friday. If we are unable to take your call, leave a message and we will return your call within 48 hours.

Internal Use Only - Please do not write below this line

Receipt Date: _____ ○ Complaint ○ Appeal Received By: _____

Type: ○ Clinical ○ Potential QOCC ○ Benefit ○ Pharmacy ○ Claim ○ Other