

If you need assistance understanding the information in this document, including written or oral translation, we can help you.

You can get help by calling **Health Plan Services** at **303-602-2100, 1-800-700-8140**, or State Relay 711 for callers with speech or hearing disabilities. Si necesita esta carta en letras grandes, casete, o en otro idioma, por favor llámenos al 1-800-700-8140.

Si desea usar el servicio TTY, llame a 711.

Completion of this form is voluntary. You or your authorized/personal representative must submit this request within 60 calendar days of an adverse benefit determination notification letter for an appeal or at any time for a grievance (also known as a complaint). 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, Inc.
Attn: Grievance and Appeals Department
938 Bannock St.
Denver, CO 80204
Fax: 303-602-2078
denverhealthmedicalplan.org

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:

Name (Last, First, Middle Initial)

Telephone #

Mailing Address

City, State, Zip Code

Relationship to Member (check one): Spouse Son/Daughter Parent/Legal Guardian

Friend/Significant Other Provider/Physician* Attorney

Other (please specify) _____

***Important Note: By indicating a "check" in the Provider/Physician representation box above, the provider and/or physician 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 from 8 a.m. to 5 p.m. Monday through Friday. If we are unable to take your call, please leave a message and we will return your call within 48 hours.