DENVER HEALTH MEDICAL PLAN INC.™

COMPLAINT AND APPEAL FORM

Using this form is your choice. **FOR MEDICAID, CHP+ OR MEDICARE MEMBERS:** you or your authorized/personal representative have **60 days** from the date of an adverse benefit determination notification letter for an appeal. For all other plan members, you have **180 days**. For a grievance (also known as a complaint), you can file at any time. Please attach copies of all documents which may support your request. If this is an urgent request please call the Denver Health Medical Plan, Inc. (DHMP) Complaint and Appeal Department at 303-602-2261.

FOR MEDICAID & CHP+ MEMBERS: If you have questions about this notice, we can help you for free. We can also give it to you in other formats like large print, audio or in other languages. For Medicaid: call 303-602-2116 or toll free 1-855-281-2418. For CHP+: call 303-602-2100 or toll free 1-800-700-8140. Call 711 for callers with speech or hearing needs. Si tiene preguntas acerca de este aviso, podemos ayudarlo sin costo alguno. También podemos ofrecerlo en otros formatos como letras grandes, audio u otros idiomas. Llame al 303-602-2116, sin costo al 1-855-281-2418 o al 711 para personas que llaman con necesidades auditivas o del habla.

This form and any documents may be mailed or faxed to:

Denver Health Medical Plan
Attn: Complaint and Appeal Department
777 Bannock St., MC 6000
Denver, CO 80204
Fax: 303-602-2078

DHMP PLAN TYPE (PLEASE CHECK ONE):

Elevate Exchange

- ○ Bronze Standard
- ○ Bronze HDHP
- ○ Silver Standard
- ○ Silver Select
- ○ Gold Standard
- ○ Gold Select

Elevate Colorado Option

- ○ Bronze
- ○ Silver
- ○ Gold

Elevate Medicare Advantage

- ○ Elevate Medicare Choice (HMO D-SNP)
- ○ Elevate Medicare Select (HMO)

Elevate Child Health Plan Plus

- ○ CHP+

Elevate Medicaid Choice

- ○ Medicaid Choice

DHHA Employer Group

- ○ Medical Care HMO
- ○ HighPoint HMO
- ○ HighPoint Point of Service (POS)

PLEASE FILL OUT THE FORM BELOW. USE THE PERSON'S INFORMATION THAT THE COMPLAINT OR APPEAL IS BEING SUBMITTED FOR:

Name (Last, First, Middle Initial) DOB (MM/DD/YYYY)

Member ID # Phone #

Home Address

City State Zip

IF YOU ARE SENDING THIS FORM IN FOR SOMEONE ELSE:

You will need to upload an Appointment of Representative (AOR) form with this complaint or appeal.

» For Medicare members, use the Appointment of Representative form, found here: **https://www.denverhealthmedicalplan.org/medicare-appointment-representative-form**

» For Medicaid, CHP+, Exchange, Colorado Option and DHHA members, use the DHMP Appointment of Representative form, found here: **https://www.denverhealthmedicalplan.org/appointment-personal-representative-form**

Without an Appointment of Representative Form, we will not be able to process your complaint or appeal. Exception: physicians acting for their Medicare member patients do not need to send in the AOR form.

Name (Last, First, Middle Initial) Phone #

Mailing Address

City State Zip

Relationship to Member

- ○ Spouse
- ○ Child
- ○ Parent/Legal Guardian
- ○ Friend/Significant Other
- ○ Provider/Physician
- ○ Lawyer
- ○ Other _____

NOTE: Choosing 'Provider/Physician' above means 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 for a complaint, please tell us about the issue below. If you are filing an appeal, please go to Section B. Have dates of service and staff names, if you can. You may add more pages and/or supporting records, if needed.

SECTION B: APPEAL

For an appeal to an already denied service or claim, please fill out the questions below.

Is this in regard to a denied claim?

○ Yes

○ No

If yes, please give us:

Claim # Provider Name

Date(s) of Service

Or is this in regard to a denied medical visit or treatment?

○ Yes

○ No

If yes, what is the date of the Denial Letter: _____

Please give us the reason and a brief description of your appeal. You may upload more pages and/or supporting documentation, if needed.

Member Signature Date

Authorized Representative Signature Date