DENVER HEALTH MEDICAL PLAN INC.™

COMPLAINT AND APPEAL FORM

Using this form is your choice; it is not required.
If this is an urgent request, please call the Denver Health Medical Plan, Inc. (DHMP) **Health Plan Services 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, faxed or emailed to:

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

SUBMISSION TIMELINES:

Please be aware that there are filing deadlines for any complaint/grievance or appeal. Any complaint filed beyond the allowed times, will be dismissed without processing.

Grievances:

» Medicare Plans: 60 calendar days from date of occurrence/event

» DHHA Employer Plan and Exchange/CO Option Plans: 180 days from occurrence/event

» Medicaid and CHP+ Plans: unlimited – no deadline restriction

Appeals:

» Medicare Plans: 65 calendar days from adverse determination

» DHHA Employer Plan and Exchange/CO Option Plans: 180 calendar days from adverse determination (Standard), 24 hours (Urgent)

» Medicaid and CHP+ Plans: 60 calendar days from adverse determination (Standard), 10 days (Urgent)

DHMP PLAN TYPE (PLEASE CHECK ONE):

- ☐ **Elevate Health Plans Exchange/CO Option**
- ☐ **Elevate Medicare Advantage**
- ☐ **Elevate Child Health Plan *Plus***
- ☐ **Elevate Medicaid Choice**
- ☐ **DHHA Employer Plans**

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, PLEASE PROVIDE YOUR INFORMATION BELOW.

You will need to upload a signed copy of the Appointment of Representative (AOR) form with this complaint or appeal.

» For Medicare members, use the CMS 1696 Appointment of Representative form, found here: **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207**

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

Without a member-signed 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 CMS 1696 AOR form.*

Submitter's Name (Last, First, Middle Initial) Submitter's Phone #

Relationship to Member

- o **Family Member**
- o **Medical Provider**
- o **Other** _____

COMPLAINT OR APPEAL DETAILS:

Please describe your complaint or appeal below. Be as thorough as possible. You may add more pages and/or supporting documents, if needed.

Claim # or Authorization #

Date(s) of Service

Provider Name

SIGN AND DATE:

Member Signature Date

Authorized Representative Signature Date