Member Appeal Form

Complete and mail or fax to:
Buckeye Health Plan – MyCare Ohio
Attention: Appeals 7700 Forsyth Blve. | St. Louis, MO | 63105
Fax: 1-844-273-2641

As a member of Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) you have the right to file an appeal for any denials related to medical services or prescription drug coverage. You may file appeal requests in writing or by calling Member Services at 1-866-549-8289 / TTY/TDD 711, Monday through Friday, 8:00 a.m. to 8:00 p.m. On weekends and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Buckeye Health Plan – MyCare Ohio will give you a decision within the following timeframes from receiving your request:

Standard Medical Pre-Service Appeals:	**15 calendar days**
Standard Prescription Drug Related Appeals:	**7 days**
Expedited Medical Pre-Service Appeals:	**72 hours**
Expedited Prescription Drug Related Appeals:	**72 hours**

If we need more information and the delay is in your best interest or if you ask for more time, we have up to 14 more calendar days. We will tell you or your representative in writing if we decide to take extra days to make the decision.

Member's Name: Last_____ First _____

Medicare ID Number:_____ Member Date of Birth: _____

Relationship to Member* (please choose one): ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse Other: _____

**If other than "Self" is selected, required proof of guardianship, power of attorney or an Appointment of Representative (AOR) form will be required. The AOR form can be found on our Resources/Materials website tab.*

Name of Person Submitting the Appeal: _____

Phone Number(s): Home:_____ Cell: _____

Street Address: _____

City:_____ State:_____ Zip:_____ County: _____

Physician: _____

*****Expedited or fast appeals*** *mean you feel that using the standard deadlines could cause serious harm to your life or health or jeopardize your ability to regain maximum function. You must also be asking for coverage for medical care or a drug you have not yet received. If you are requesting an expedited or fast appeal, explain here why you need a fast appeal decision:*_____

_____

_____

_____

Appeal Type (please choose one):

☐ Standard Pre-Service (Medical) Appeal – (15 day review)

☐ Fast* Pre-Service (Medical) Appeal – (72 hour review)

☐ Standard Part D (Prescription Drug) Appeal – (7 day review)

☐ Fast* Part D (Prescription Drug) Appeal – (72 hour review)

What was denied? (Please include a copy of the denial letter.)

_____

_____

_____

_____

_____

_____

Why do you think you should have this medical services/prescription or payment?

_____

_____

_____

_____

_____

_____

What is the best way to reach you regarding this appeal? (please choose one): ☐ Phone ☐ Email
☐ Other: _____

Signature of Person Appealing:_____ Date: _____

Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

Buckeye complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-866-549-8289 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-549-8289 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-549-8289（TTY：711）。

For Administrative Use Only
*Appeal Number:*_____*Date Received:* _____

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