Member Appeal Form

Complete and mail or fax to:
Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan)
Attention: Appeals and Grievances – Medicare Operations
7700 Forsyth Blvd | 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. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. Buckeye 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 calendar 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: _____

buckeye health plan

MyCareOhio
Connecting Medicare + Medicaid

**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 calendar days)

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

☐ Standard Part D (Prescription Drug) Appeal – (7 Calendar days 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.

For Administrative Use Only

Appeal Number: _____ *Date Received:* _____

Notice of Non-Discrimination. Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Buckeye Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Buckeye Health Plan:
- → Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- → Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Buckeye Health Plan's Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you believe that Buckeye Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Buckeye Health Plan's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-549-8289 (TTY: 711).

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

Chinese Mandarin: 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)。

Chinese Cantonese: 注意：如果您說中文，您可獲得免費的語言協助服務。請致電 1-866-549-8289 (TTY: 711)。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-549-8289 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-549-8289 (رقم هاتف الصم والبكم: 711).

Pennsylvania Dutch: Geb Acht: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-866-549-8289 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-549-8289 (телетайп: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-549-8289 (ATS : 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-549-8289 (TTY: 711).

Cushite (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-866-549-8289 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-549-8289 (TTY: 711) 번으로 전화해 주십시오.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-549-8289 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-866-549-8289 (TTY: 711) まで、お電話にてご連絡ください。

Dutch: AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-866-549-8289 (TTY: 711).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-549-8289 (телетайп: 711).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-866-549-8289 (TTY: 711).

Somali: LA SOCO: Haddii aad ku hadasho Ingiriisi, adeegyada taageerada luqada, oo bilaash ah, ayaad heli kartaa, Wac 1-866-549-8289 (TTY: 711).

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-866-549-8289 (टिटिवाइ: 711)।