

Member Appeal Form

Complete and mail or fax to:

Buckeye Community Health Plan – MyCare Ohio | Attention: Appeals
4349 Easton Way, Suite 200 | Columbus, OH | 43219 | Fax: 1-877-861-6722

As a member of Buckeye Community 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 1-800-750-0750, Monday through Sunday 8:00 AM to 8:00 PM. Buckeye Community 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 Community Health Plan is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other languages. Call 1-866-549-8289. The call is free. TTY users call 1-800-750-0750. Hours are Monday through Sunday 8:00 AM to 8:00 PM.

Usted puede obtener esta información de forma gratuita en otros idiomas. Llame a 1-866-549-8289. La llamada es gratuita. Usuarios de TTY deben llamar al 1-800-750-0750. El horario es de lunes a domingo de 8:00 AM a 8:00 PM.

For Administrative Use Only

Appeal Number: _____ Date Received: _____