HealthPlans, Inc.

Member Appeal

Please use this form when submitting an appeal to Health Plans, Inc. To avoid delays in processing your appeal, please attach all relevant information and fax or mail it with this form.

Step 1

Member ID: Patient Name:

Address:

Patient's Date of Birth: Date of Service:

Claim # (if available): Telephone #: Email:

Step 2

Please tell us what you are appealing:

☐ A denial for:

- ☐ Service not covered.
- ☐ Precertification not obtained.
- ☐ Not medically necessary.
- ☐ Prior authorization not obtained.

☐ A payment amount.

☐ A deductible amount.

☐ Use of a non-network provider.

☐ Other:

Step 3

Please provide a brief description of your appeal:

Step 4

☐ ***Documentation is attached.***

Step 5

Please send this form and supporting documentation to:

Health Plans, Inc.
Member Appeals Department
P.O. Box 5199
Westborough, MA 01581

Fax 508-754-9664