

CDPHP® Medicare Advantage



# Member Appeal Form

If you wish to file a formal appeal for CDPHP® to reverse a decision, please complete this form and return it to our appeals department. If available, please provide any additional information from providers that may help us better understand your case. The information you provide will assist us with investigating your appeal request. Please include your signature on page 2.

If someone else is completing this form for you, you must ensure that CDPHP has the appropriate forms on file. If you have selected this person to act as your representative (friend, relative, lawyer), please attach a completed Appointment of Representative form (available in the Medicare Members section on [www.cdphp.com](http://www.cdphp.com)). This form will be valid from one year from the date that the form is completed and will allow your representatives access to private health information regarding your appeal.

If your representative has been granted Power of Attorney, please attach a copy of your legal papers validating this representation and/or another form recognized as valid appointment of the state.

CDPHP is unable to proceed with your appeal until valid authorization is on file.

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## Member Information

Name of Member Involved: \_\_\_\_\_ Member ID: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Name of Person Filing Appeal (if different): \_\_\_\_\_

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## Appeal Information

If claim related—claim number(s): \_\_\_\_\_

If authorization related—determination number: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

Provider(s): \_\_\_\_\_

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Provide appeal details below

*(Use the back of this form if additional space is needed)*

Signature of Representative: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Signature of Member (required): \_\_\_\_\_ Today's Date: \_\_\_\_\_

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Based on the information you have provided, CDPHP will make every effort to resolve your appeal in a satisfactory and timely manner.

Return to: CDPHP  
Attn: Medicare Appeals and Grievances  
PO Box 66209  
Albany, NY 12206

*The appeal process will not begin until this form is received by CDPHP. Please return promptly!*

Capital District Physicians' Health Plan, Inc. | CDPHP Universal Benefits,® Inc.