

MEMBER APPEAL FORM

Member Information:

Name of Member involved in Appeal: _____ CIN #: _____

Head of Household/Guardian: _____ File #: _____

Address: _____ Telephone #: _____

Explanation of Incident/Appeal:

Reason(s) for Appeal:

How would you like your appeal resolved/determined:

Signature of Appellant or Designee: _____ Date: _____

Please return this form to: Suffolk Health Plan
4944 Parkway Plaza Blvd, Suite 110
Charlotte, NC 28217
Attn: Appeals Unit or fax to 800-338-4195

You have no less than sixty (60) business days from the date you received the determination letter to file an appeal. For assistance in completing this form, please call our Member Services Department at 1-877-747-6789.

For Official Use Only — Please do not write below this line

Receipt of the Appeal (Date): _____ Received by: _____

Clinical Appeal: No Yes If yes, refer to: _____ Date referred: _____

Reviewed and approved by (Signature): _____ Date: _____