brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

APPEAL FORM

This form is for your use when filing an appeal about the plan's decision to not cover medical care or prescription drugs. If you have any questions, please feel free to call the Brand New Day Member Services Department at 1-866-255-4795, TTY 711, 8 am - 8 pm 7 days a week .

PLEASE PRINT THE FOLLOWING INFORMATION ABOUT YOURSELF:

Member Name: _____ Member ID#: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

APPOINTMENT OF REPRESENTATION FOR APPEAL

You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "Representative" to make an appeal. There may be someone already legally authorized to act as your representative under state law. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form or go to our website at www.bndhmo.com/Members/Resources and scroll to the bottom of the page under "Forms". You can also complete the information below about the person you are naming to act for this appeal only. We cannot start review of appeals from someone other than you unless we have the completed "Appointment of Representative" form or other proof of legal authorization for someone to act for you.

If choosing a Representative, please complete the following information:
I appoint the following person to act for me for this appeal:

Representative's Name: _____

Representative's Address: _____

Representative's Telephone: _____

Relationship to Member: _____

Member Signature: _____ Date: _____

Representative Signature: _____ Date: _____

INFORMATION ABOUT YOUR APPEAL:

Use the space below to help describe your appeal. Please attach copies of any additional information that may help us with your appeal.

Item or Service You Wish to Appeal: _____

Drug Name: _____ Dosage/Strength: _____

Provider Name: _____

Date(s): _____ Claim Number: _____ Claim Amount: _____

Describe the Reason for Your Appeal: _____

_____

_____

_____

_____

_____

_____

_____

_____

Member or Representative Signature: _____ Date: _____

Mail completed form to:

Brand New Day
ATTN: Appeals & Grievance Department
PO Box 93122
Long Beach, CA 90809
or Fax: 1-657-400-1217