University
HEALTH CARE
ADVANTAGE

# HOW TO SUBMIT YOUR MEDICARE PART C MEDICAL SERVICES APPEAL

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Your appeal is handled by different reviewers than those who made the original unfavorable decision.

**Expedited** Medicare Appeals can be requested by calling University Health Care Advantage at 1-855-996-8422 (TTY: 711)

**Standard** Medicare Appeals must be in writing and signed by the Member.

If the appeal is requested by a doctor or a family member, an Appointment of Representative Form (AOR) must be signed by the member and the representative. If you require this form, you can download a copy at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html, or contact University Health Care Advantage at 1-855-996-8422 (TTY: 711) from 8:00 a.m. to 8:00 p.m., seven days a week.

Please send your written appeal to:

**University Health Care Advantage**
**Attn: Grievance & Appeals Department**
**P.O. 21420**
**El Sobrante, CA 94820**
**Fax: 510-291-2238**

If you have any questions, please call our Member Services Department at **1-855-996-8422 (TTY 711) from 8:00 a.m. to 8:00 p.m., 7 days a week.**

One of our representatives will be happy to assist you.

**PLEASE SUBMIT ANY SUPPORTING DOCUMENTS WITH YOUR APPEAL**

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**MEDICARE PART C - MEDICAL SERVICES**
**MEDICARE WRITTEN APPEAL FORM**

You have a right to an appeal if you believe you are entitled to a service or benefit that has been denied. Please complete the following information to file an appeal:

| **PROCESSING TIME**<br>**Standard pre-service = 30 Days**<br>**Standard post-service and all Claims = 60 days**<br>**Expedited pre-service appeals = 72 Hours** |
|---|

An **expedited** appeal is only available when the standard process could seriously jeopardize life, health, or the ability to regain maximum function. Expedited requests not meeting one of these criteria will be transferred to the **standard** process.

**ALL CLAIM APPEALS ARE PROCESSED AS STANDARD APPEALS**

☐ **Request for Standard Appeal** **or** ☐ **Request for Expedited Appeal**

**Member Name:** ___________________________________ **Member ID:** _______________________________

**Address:**____________________________________________________________________________________

*(street, city, state, zip)*

**Member Phone #:** _______________________________**Alternate #:** _________________________________

**Provider Name:** _____________________________________ **Provider Phone :**________________________

**Provider Mailing Address:**

___________________________________________________________________________________________

***Please describe what was denied:***

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

***Please describe why you believe you are entitled to the denied service or benefit:***

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

**Member Signature:**

___________________________________________________________________________________________

**Name of Person Submitting Appeal (if applicable):** **Date:**

___________________________________________________________________________________________

**Signature of Person Submitting Appeal (if applicable):** **Date:**

___________________________________________________________________________________________