Oscar Appeal Form

If you (or someone acting on your behalf or your provider of record) would like to file an appeal of a denied authorization request related to medical necessity issued by Oscar, this form can be completed and submitted to Oscar. While it is not required to complete this form in order for your appeal request to be accepted, it may help Oscar in processing your request. If you have any questions or would like to request more information, you or your doctor can call us at 1-855-672-2755 (855-OSCAR-55), or message us in the Oscar app or at hioscar.com.

Member Information	
Name (first and last):	Oscar ID#:
DOB (mm/dd/yyyy):	Phone Number:
Address:	Name & relationship to member of person acting on member's behalf (if applicable):

Summary of Denied Authorization Request	
Service(s) Denied:	Date(s) of Service:
This appeal is related to a: ❒ Pre-service request ❒ Post-service request ❒ Concurrent request	Provider Name:
This appeal request should be considered URGENT: ❒ Yes ❒ No	Case Number (MEDREV-XXXXX):

Please use this space to explain your appeal request, and the disagreement with Oscar's decision:

Appealing party's signature:	Today's date (mm/dd/yyyy):

Please fax this form along with supporting clinical information to 844-965-9054.