Name: Oscar Health Plan, Inc.
Attention: Clinical Appeals
Address: P.O. Box 52146, Phoenix, AZ 85072
Phone: 1-855-672-2755
Fax: 1-844-965-9053

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name _____ Member ID # _____
Name of representative pursuing appeal, if different from above_____
Mailing Address _____ Phone # _____
City _____ State _____ Zip Code _____

Type of Denial: ☐ Denied Claim ☐ Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____
_____
_____
(*Explain what you want your insurer to authorize or pay for*.)

Explain why you believe the claim or service should be covered:
_____
_____
_____
_____
_____
_____
_____
(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548, or Oscar Health Plan, Inc. at _____1-855-672-2788_____.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: ☐ Medical records ☐ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) **Also attach the certification from your treating provider if you are seeking expedited review.

_____ _____
Signature of insured or authorized representative Date