Oscar Grievance and Appeal Form - New York

We encourage the form to be completed and returned to Oscar to best assist you in resolving your grievance or appeal. However, completion of this form is optional. For a full list of methods to submit your grievance or appeal, please reference your Evidence of Coverage (EOC) or call Oscar's Member Services Department using the telephone number displayed on your member identification card.

1. Member Information:

Member Name: _____ Member ID #: OSC_____

Complainant/Appellant Name (if different from member): _____

Relationship to Member_____

Home Address:
_____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Date of Birth: _____

2. To assist Oscar in reviewing your appeal or grievance, please summarize the issue and the action desired. Please attach all supporting documentation.

Is your issue regarding:

- ❑ Medication
- ❑ Medical Service or Equipment
- ❑ An issue not related to a specific medical service or medication
- ❑ A denial, reduction of or a failure to provide or make payment for services

For a specific medical service or medication, please provide the details:

Service or Medication: _____

Provider (Physician, Facility, Prescriber): _____

Service Date: _____

Claim ID(s): _____

Have you already received services?

- ❑ Yes
- ❑ No

Please describe the nature of your grievance or appeal below (please use additional pages if necessary). Add any facts that you feel should be considered in the review of your grievance or appeal. As a reminder, please attach any supporting documentation that you have.

If you are the person who received the services and you want someone else to speak on your behalf, please complete the HIPAA authorization form and attach.

If you are attempting to submit an urgent appeal or grievance, that includes imminent danger to your life, life, or state of health, please contact 855-672-2755 to initiate an urgent appeal or grievance request.

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3. Do you need to appoint a representative?

Skip this section if you are the member acting on behalf of yourself.

If you are not the member and aren't sure if you're authorized to work with Oscar on the member's behalf, please complete this section with the member.
I _____, appoint _____ to act on behalf of _____ in connection with any claim for coverage or benefits identified in this case including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan only in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

Member's Oscar ID Number: _____

Representative Name: _____ Relationship to Member: _____

Representative's Address:_____

City: _____ State: _____ Zip: _____

Representative Phone Number: _____

4. Signature and Submission

I acknowledge that the information contained within this form is accurate to the best of my knowledge. I have provided complete and accurate information upon which to base an investigation of the circumstances surrounding the issue. I agree to cooperate and provide any additional information necessary and/or appropriate related to this grievance. My failure to do so may result in Oscar closing the investigation related to this matter.

Signature:_____ Date: _____

Name (Printed): _____

Please submit this completed form **(Attn: Grievances)** to one of the following:

By mail:
Oscar Insurance
Attn: Grievances
P.O. Box 52146
Phoenix AZ, 85072

By email:
help@hioscar.com
Attn: Grievances

By fax:
888-977-2062
Attn: Grievances