



## Oscar Grievance and Appeal Form - Mississippi

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.

### 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: \_\_\_\_\_

**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:

- |                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Medical Service or Equipment | <input type="checkbox"/> An issue not related to a specific medical service or medication | <input type="checkbox"/> 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, limb, or state of health, please contact 1-855-672-2755 to initiate an urgent appeal or grievance request.



### 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 ID Number: \_\_\_\_\_

Representative Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Representative's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Representative Phone Number: \_\_\_\_\_

### 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  
P.O. Box 52146  
Phoenix AZ, 85072

**By fax:**

888-977-2062

**By email:**

[help@hioscar.com](mailto:help@hioscar.com)