# Member Appeal/Complaint Request ~~e~~-Form

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| **Name of member for whom the appeal/complaint is being filed:** | |
| **Name of person filing appeal/complaint:** | |
| **Date:** | **Member ID:** |
| **Is this person the (check one):**<br>☐ Policyholder ☐ Member (if different than Policyholder) ☐ Authorized Representative | |
| **Contact information of the person filing the appeal/complaint**<br>**Complete mailing address:** | |
| **Phone:** | **Fax (if applicable):** |
| **Communication by email is OK:** ☐ **Email address (if box to the left is checked):** | |
| If you have given Friday Health Plans appropriate consent for an Individual to act on your behalf, Friday Health Plans will send response acknowledgement/appeal or complaint correspondence to that individual. | |
| **Are you requesting an urgent appeal? ("urgent" means your life, health, or ability to maintain function is in jeopardy.)** ☐ Yes ☐ No | |
| **Briefly describe your dissatisfaction or why you disagree with our decision not to approve the requested service/benefit** (you may attach additional information such as a physician's letter, bills, medical records, or other documents to support your claim): | |

**Send this form, your denial notice, and any supporting documentation to:**

Friday Health Plans ATTN: Appeals and Grievances
700 Main St.
Alamosa, CO 81101
Ph: 1-844-451-4444
Fax: 1-844-280-1794
Email: appeals@fridayhealthplans.com

**Be sure to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.**