MEMBER APPEAL FORM

Member's Name _____ Member's Date of Birth _____

Member's ID Number _____ Member's Medical Records # _____

Name of member's Designated Personal Representative/Guardian
(please see DPR form/Attachment C at the end of the handbook)

_____

Date of Initial Denial Letter _____

What was denied? _____

Reason for the denial (as noted in the letter) _____

_____

Describe any new information since the initial review of this matter:

_____

_____

_____

_____

Signature _____
Of Member or Member's Designated Representative/Guardian

Date _____

Please send to: **Colorado Choice Health Plans**
Attn: Member Services –
700 Main Street, Suite 100
Alamosa, CO 81101
Phone: 719-589-3696