

**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: **Friday Health Plans of Colorado**

Attn: Member Services –  
700 Main Street, Suite 100  
Alamosa, CO 81101  
Phone: 719-589-3696



Call us at 1-800-475-8466 or 719-589-3696 if you need help or have questions