Contact the phone number on the back of your member identification card for assistance with filling out this form.

APPEAL FORM

Please return completed form to:

Commercial and Individual	Self-Funded Groups (ASO)	MedAdvantage	FEP
Asuris Northwest Health	Asuris Northwest Health	Medicare Advantage	Regence – FEP
Attn: Asuris Level 1 Member Appeals	Attn: ASO Appeals	Attn: Appeals MSB32AG	PO Box 1388
PO Box 1408	PO Box 2998	PO Box 1827	Medford, OR 97501
Lewiston, ID 83501	Tacoma, WA 98401-2998	Medford, OR 97501	Lewiston, ID 83501-9998
or via fax at 1 (888) 496-1542	or via fax at 1 (877) 663-7526	or via fax at 1 (888) 309-8784	

Patient Name	Date of Birth	Phone Number
Address	City, State, ZIP Code	E-Mail Address (optional)
Identification Number (numerics only, without alpha prefix)	Group Number	Today's Date
Doctor/Hospital Name	Date(s) of Service or Incident	
Claim Numbers (if available)		

Note: 1) Appeals must be received within 180 days from the date of initial adverse determination.

2) If you are initiating an appeal on behalf of another person who is not a minor, Asuris Northwest Health (Asuris) must also receive a completed HIPAA authorization form, signed by that person, which can be found on the myasuris.com website.

Please explain the problem. Include background, time frames, and the names of anyone else you have spoken with to try and resolve the problem, any supporting documentation, and your expectations or suggestions for resolution.

List any supporting documentation attached to this form:

We need your permission to authorize Asuris to request any medical records needed to answer your appeal. This includes information about alcohol or drug abuse, mental health, AIDS or HIV virus, if applicable. This authorization begins today and remains in effect so long as your appeal is being reviewed. You will receive an acknowledgment letter for this appeal with information about the appeals process.

PRINTED NAME

RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE *
(Patient's parent/guardian may sign if patient is a minor child)

TODAY'S DATE

THIS SECTION TO BE COMPLETED BY OFFICE STAFF	Did the member fax or mail in supporting documentation? Check box if Yes ☐ Did the member provide this authorization verbally? Check box if Yes ☐

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