

Appeals and Grievances Request Form

PLEASE CHECK THE APPROPRIATE BOX:

Appeal/Grievance Expedited Appeal/Grievance (as specified by us or your provider) Second Level Appeal/Grievance (for group members only)

PERSON COMPLETING FORM:

Member Spouse Authorized Representative Parent/Guardian Provider (related to the appeal or grievance)

MEMBER INFORMATION:

First Name	Last Name	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Date of Birth	Member ID	<input type="checkbox"/> Off-Exchange	<input type="checkbox"/> On-Exchange	
Home Phone		Cell Phone		
Home Address	City	State	Zip	

SERVICE PROVIDER INFORMATION:

First Name	Middle Initial	Last Name	
<input type="checkbox"/> In-Network	<input type="checkbox"/> Out-of-Network	Specialty	
NPI	TIN		
Office Phone	Fax	Email	
Provider Address	City	State	Zip

APPEAL/GRIEVANCE INFORMATION:

Date(s) of Service
Procedure/Type of Service
Date of Initial Denial
Date of Appeal or Grievance Determination (for group members only)

DESCRIPTION OF THE APPEAL/GRIEVANCE (For clinical appeals, please submit clinical documentation)

Member/Authorized Representative*/Provider Signature _____ Date _____

*Please complete the Appointment of Representative form and HIPAA authorization or other appropriate documentation showing legal authority to act as the Authorized Representative of the member (e.g., power of attorney, court order of guardianship).

RETURN THE FORM AND SUPPORTING DOCUMENTS AND INFORMATION TO CARECONNECT BY:

MAIL	EMAIL	FAX
CareConnect Attn: Appeals and Grievance Department 2200 Northern Blvd, Suite 104, East Hills, NY 11548	CareConnectAppeals@careconnect.com	844-447-2525

CareConnect Insurance Company, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-226-7318 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-226-7318 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-855-226-7318 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-226-7318 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-226-7318 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-226-7318 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-226-7318 (TTY: 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-226-7318 (TTY: 711).

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-226-7318 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-226-7318 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-226-7318 (رقم هاتف الصم والبكم: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-226-7318 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-855-226-7318 (TTY: 711)۔

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-226-7318 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-226-7318 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-226-7318 (TTY: 711).