Acentra HEALTH

Mississippi's State and School Employees' Health Insurance Plan

Request for Appeal Form

1. **Standard Appeal:** The appellant submits the Request for Appeal form within 180 days of the denial date. Acentra Health will conduct a full and fair review of your claim and provide you with a written determination. Additional documentation will be considered. Acentra Health renders a decision in writing within 60 days of receiving the Request for Appeal.
2. **External Appeal:** The appellant submits the Request for Appeal Form within four (4) months of receiving the Final Internal Denial decision notice. External physicians with expertise in the medical service or supply at issue coordinated by an Independent Review Organization (IRO) conduct a full and fair review of the claim. If the treating physician determines that a delay in decision-making may seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, an **Expedited External Appeal** may be requested. **The External Appeal decision is final and binding. No additional reviews are available.**
3. **Please mail or fax this completed form** and all other documentation supporting the appeal request to: Acentra Health 6802 Paragon Place, Suite 440 Richmond, Virginia 23230 | Fax 833-505-1992.

Type of Appeal Requested: ☐ Standard Appeal ☐ External Appeal

Confirm required attachment: ☐ Denial letter

Participant Name:	Participant ID# (from insurance card):
Participant Address:	
Phone Number:	Work Number: Cell Number:
Acentra Health Reference Number:	

Treating Health Care Provider Name:	☐ **Check if Expedited External Appeal**
Provider Mailing Address:	
Provider Contact Person:	Phone Number:
Licensure or Area of Clinical Specialty:	

Physician Certification for Expedited External Appeal: I certify that waiting the full 30-day determination period would jeopardize the life or health of the participant or the participant's ability to regain maximum function.

Signature of Physician (ONLY if Expedited): X Date:

Summary of Appeal Request (use additional pages if needed):

Participant consent (required for External Appeal): By signing below, I consent the release by the State and School Employees' Health Insurance Plan (Plan) or any affiliated entity and the participant's health care provider of all confidential medical information to the IRO and its reviewer for the purpose of reviewing the denial. This consent includes release of all confidential information relating to mental/behavioral health, substance abuse and HIV/AIDS, if applicable. This consent is valid for one year and may be revoked at any time upon written notice to the Plan. I understand that another person may request an External Appeal on my behalf with my consent. If I have such person sign below, I consent to having such person ("My Authorized Representative") request an External Appeal on my behalf and to receive all communications related thereto.

(SIGNATURE REQUIRED) Signature of Participant or Legal Representative X	**Phone number** ( ) -
Printed Name	**Date**
Authorized Representative Signature	**Phone number** ( ) -
Printed Name	**Date**
Authorized Representative mailing address, if different than participant address	