SAMARITAN ADVANTAGE HEALTH PLAN • 2300 NW WALNUT BLVD. • CORVALLIS, OR 97330

APPEAL REQUEST FORM

Please complete this form and return it to us. Make sure that you have signed and dated the form. For help with this form, please call Customer Service, Monday – Friday, 8 a.m. to 8 p.m.:

- In Corvallis at 541-768-4550
- Toll-free at 1-800-832-4580
- TTY users should call 1-800-735-2900

For Internal Use Only:

This form is for Samaritan Advantage Members Only

1. MEMBER INFORMATION

This should be the person whose name is on the denial letter, bill, or explanation of benefits (EOB):

First name:	Last name:	
Address:		
City:	State:	Zip:
Member ID#:	Phone:	

2. WHAT DECISION DO YOU WANT US TO CHANGE?

Note: You may attach papers to this form to help explain your request. For example, you may want to include:

- A letter from your doctor or a copy of your medical records
- Bills or explanation of benefits (EOB) that you have received
- The denial letter

TURN PAGE OVER TO FINISH THE FORM ▶ ▶ ▶

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3. WHY DO YOU THINK WE SHOULD CHANGE THE DECISION? Please use a blank page if you need more space.

4. YOU CAN ASK US TO MAKE A FAST (EXPEDITED) DECISION ON YOUR APPEAL.

You can ask us to decide faster than usual if:

1. You think your health or mental health may be in serious danger, or
2. Your doctor says that waiting the usual amount of time for us to decide would put your life in serious danger, or
3. Your doctor says you have pain that cannot be controlled.

Check this box if you want a fast decision on your appeal. ❑

5. SIGN AND DATE THIS FORM. If you have not signed and dated this form, we will not process your request.

If this request is for a child who is 18 or younger, their parent or legal guardian must sign:

Signature: _____ Today's date: _____
(mm/dd/yy)

Relationship to Member:

❑ Self

❑ Treating Physician: Pre-Service only, Contracted and Non-Contracted (no documentation required)

❑ Treating Provider/Prescriber appealing for member (Supporting documentation required)

❑ Treating Provider/Prescriber (contracted) appealing denied payment (CMS form 1696 required)

❑ Treating Provider/Prescriber (non-contracted) appealing denied payment (Waiver of Liability required)

You can choose to fax the form, mail or bring it to us in person.

- Email to: SHPOAppealsteam@samhealth.org
- Fax: 541-768-9765
- Mail to: Samaritan Advantage Health Plans – Appeal Team, P.O. Box 1310, Corvallis, OR 97339
- Visit us at: 2300 NW Walnut Blvd, Corvallis, OR 97330

IMPORTANT: Keep copies of this form and all other papers that have to do with this request.