



Member Appeal Form

Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan)
Attention: Appeals and Grievances – Medicare Operations
7700 Forsyth Blvd | St. Louis, MO | 63105
Fax: 1-844-273-2641

As a member of Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) you have the right to file an appeal for any denials related to medical services (Part C) or prescription drug (Part B) coverage. You may file appeal requests in writing or by calling Member Services at 1-866-549-8289 / TTY: 711, Monday through Friday, 8:00 a.m. to 8:00 p.m. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. Buckeye will give you a decision within the following timeframes from receiving your request:

- Standard Medical Pre-Service Appeals: **15 calendar days**
- Standard Part B Prescription Drug Related Appeals: **7 calendar days**
- Expedited Medical Pre-Service Appeals: **72 hours**
- Expedited Part B Prescription Drug Related Appeals: **72 hours**

Appeals related to payment issues For Part C and Part B drugs will be given a standard appeal decision within 60 calendar days of request receipt. If we need more information and the delay is in your best interest or if you ask for more time, we have up to 14 more calendar days for Part C Pre Service. We will tell you or your representative in writing if we decide to take extra days to make the decision.

** **Expedited appeals** mean you feel that using the standard deadlines could cause serious harm to your life or health or jeopardize your ability to regain maximum function. You must also be asking for coverage for medical care or a drug you have not yet received.*

Member’s Name: Last _____ First _____

Medicare ID Number: _____

Member Date of Birth: _____

Relationship to Member* (please choose one): Self Parent Legal Guardian Spouse
 Other: _____

**If other than “Self” is selected, proof of guardianship, power of attorney or an Appointment of Representative (AOR) form will be required. The AOR form can be found on our website.*

Name of Person Submitting the Appeal: _____

Phone Number(s): Home: _____ Cell: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Physician: _____

Appeal Type (please choose one):

- Standard Pre-Service (Medical) Appeal – (15 calendar days review)
- Expedited Pre-Service (Medical Appeal – (72 hours review)
- Standard Part B (Prescription Drug) Appeal – (7 calendar days review)
- Expedited Part B (Prescription Drug) Appeal – (72 hours review)
- Standard Payment Issues Appeal (Part C and Part B drugs) – (60 calendar days review)

What was denied? (Please include a copy of the denial letter.)

Why do you think you should have <this/these> medical service(s)/prescription or payment?

What is the best way to reach you regarding this appeal? (please choose one): Phone Email
 Other: _____

Signature of Person Appealing: _____ Date: _____

If you have any questions please call our Member Services number at 1-866-549-8289 / TTY: 711, Monday through Friday, 8:00 a.m. to 8:00 p.m. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

For Administrative Use Only

Appeal Number: _____ Date Received: _____

Notice of Non-Discrimination. Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Buckeye Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Buckeye Health Plan: → Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
→ Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Buckeye Health Plan's Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you believe that Buckeye Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Buckeye Health Plan's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Services

