Medicare Advantage Member and Representative Claim Appeal

Complete this form completely and legibly. Check the box that most closely describes you as the requestor. Be sure to include any supporting documentation, as indicated below.

Address:
HealthSpring Medicare Advantage Appeals
PO Box 188081
Chattanooga, TN 37422

Fax Number:
1-855-350-8671

This appeal is being filed by: *Select one of the following.*

☐ **Me, the HealthSpring Customer** *(please print):*

Customer First Name:	MI:	Customer Last Name:	Customer ID Number:	Date of Birth:

Phone Number:	Customer's Address:	City:	State:	Zip Code:

☐ **Complete the following section ONLY if the person making this request is not the enrollee:**

Requestor's Name:	Requestor's Relationship to Customer:	Requestor's Phone #:	

Requestor's Address:	City:	State:	Zip Code:

Representation documentation for appeal requests made by someone other than enrollee:
If you want someone else (such as a family member or friend) to file an appeal for you, that person must be your representative. That person may already be your representative if you've filed paperwork with your state, such as Power of Attorney papers. Attach a completed Authorization of Representation form CMS-1696 or a written equivalent. The CMS-1696 Form can be located here: Appointment of Representative (cms.gov)

Please advise if the appeal is related to:

☐ **Are you requesting reimbursement?**

Claim ID Number:		Authorization Number: (if applicable)		Date of Service:

Provider Name:		Provider NPI:		Provider Address:

City:	State:	Zip Code:	Phone Number:	Amount being appealed:

Please explain the reasons for appeal:

Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your doctor and relevant medical records. You may want to refer to the explanation we provided in your denial.