Appeal Form

According to state guidelines, you have 60 days from the date of service, adverse decision, or initial provider bill to request an appeal. Please complete this form to the best of your ability and return it by mail, email, fax, or by hand delivery. If you have any questions while completing this form, contact the Customer Service number listed below.

Mailing Address: Attn: Appeals and Grievances Aspirus Health Plan P.O. Box 51 Minneapolis, MN 55440-9972	**Email:** cagMA@aspirushealthplan.com	**Phone:** 715-631-7440 or 1-855-931-4858 TTY/Hearing Impaired: 715-631-7413 or 1-855-931-4852 8 am – 8 pm, seven days a week **Fax:** 715-631-7439 or 1-855-931-4857

Section 1: Member Information		
Member's Name:		Date of Birth:
Member's Address:		
City:	State:	ZIP:
Daytime Phone: ( )	Member's Plan ID Number:	Medicare ID Number (HICN)/PMI #:

Section 2: Complaint Information	
☐ **Claims Denial** Date(s) of Service: _____ _____ _____ _____	☐ **Service Denial** Has service already occurred? ☐ Yes ☐ No If yes, date(s) of service: _____ _____ Type of service: _____

Provider's Name: _____ _____	☐ **Other Dispute** Other: _____ _____

Section 3: Description of your Complaint
Include additional information that will benefit your review, such as a statement from your provider, relevant medical records, denial notices, etc. (You can attach additional pages if needed.)

Section 4: Signature

I certify that the above information is true, complete, and correct to the best of my knowledge. I understand that statements or information furnished on this form will be verified and I agree to furnish supporting documents or information to Aspirus Health Plan if requested.

Signature of Member: _____ Date: _____

Member's Printed Name: _____

Only a member or their authorized representative can file a complaint with Aspirus Health Plan. If the person submitting the complaint is someone other than the member, please complete either section 5, OR both 6 and 7.

Section 5: Documentation of a Valid Representative

I have attached a copy of a valid:

☐ Authorization of Representation Form (CMS-1696)
☐ Power of Attorney (POA) Form
☐ Healthcare Proxy
☐ Estate Form
☐ Other Form Type: _____
☐ Representative information has been submitted to Aspirus Health Plan within the last 12 months
Information Submitted: _____
Date of Submission: _____

Section 6: Appointment of Representative:

Appointment of Representative

I, _____ authorize _____ to submit this
(print member's name) (print representative's name)
complaint on my behalf; to present or elicit evidence to Aspirus Health Plan; and receive any notice in connection with this complaint. I understand that personal medical information related to my complaint will be shared with my representative.

Member Signature: _____ Date: _____

Section 7: Appointment Documentation		
Acceptance of Appointment I, _____ accept the appointment to act on behalf of _____. (print representative's name) (print member's name) Representative Signature: _____ Date: _____		
Representative's Name:	Relationship to the Member:	
Address:		
City:	State:	ZIP:
Daytime Phone: ( )		

Notice of Nondiscrimination

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715-631-7411 (voice)** or toll free at **1-855-931-4850 (voice)**, **715-631-7413 (TTY)**, or **1-855-931-4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**.

If you believe that Aspirus 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 an oral or written grievance.

Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
Attn: Appeals and Grievances
Aspirus Health Plan
P.O. Box 51
Minneapolis, MN 55440
Email: cagMA@aspirushealthplan.com
Fax: 715-631-7439

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, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

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 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715-631-7411/1-855-931-4850 (телетайп: 715-631-7413/1-855-931-4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715-631-7411/1-855-931-4850 (መስማት ለተሳናቸው: 715-631-7413/1-855-931-4852).

ဟသျှဟသး-နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတၢ်မၤစၢၤလ၊ တလာ်ဘျုာ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ័ឌ្ឋ, រសវាជំនួយរ័ដ្ឋកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 715-631-7411/1-855-931-4850 (TTY715-631-7413/1-855-931-4852)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 715-631-7411/1-855-931-4850 (رقم هاتف الصم والبكم: 715-631-7413/1-855-931-4852.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715-631-7411/1-855-931-4850 (ATS : 715-631-7413/1-855-931-4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).