

Clover Health

Form for Requesting an Appeal of a Clover Health Denial

Because Clover Health (or one of our delegates) denied your request for coverage of (or payment for) medical benefits, you have the right to ask us for an appeal of our decision. You have 60 days from the date of our denial notice to ask us for an appeal. This form may be sent to us by mail or fax:

Clover Health
Attention: Appeals
P.O. Box 21672
Eagan, MN 55121
Fax: 1-732-412-9706

Expedited appeal requests can be made by phone at 1-888-778-1478.

Speech and Hearing Impaired call 711.

Who May Make a Request: Your physician may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative (see information on how to add a representative below). Contact Customer Service at 1-888-778-1478 if you have any questions. TTY users should call 711. We are open 8 am - 8 pm, local time, 7 days a week. From April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Member Information:		
Member Full Name:		
Member ID#:	Birth Date (MM/DD/YYYY): ____/____/____	Phone Number: (____) ____ - ____
Address:		
City:	State:	ZIP Code:
Complete the following section ONLY if the person making this request is not the member:		
Requestor's Name :		
Requestor's Relationship to Member:	Phone Number: (____) ____ - ____	
Address:		
City:	State:	ZIP Code:

Representation documentation for appeal requests made by someone other than member or the member's physician: If representation documentation was not submitted with the request for the organization determination, attach documentation showing the authority to represent the member (a completed Appointment of Representative (AOR) Form or other legal documentation that demonstrates representation per State law (e.g., a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute). For more information on appointing a representative and how to obtain an AOR Form, please contact Customer Service at 1-888-778-1478. TTY users should call 711. You may also contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Important Note: Expedited Decisions:

If you or your physician believes that waiting 30 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician indicates that waiting 30 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your physician's support for an expedited appeal, we will decide if your case requires a fast decision.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS. If you have a supporting statement from your physician, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your physician and relevant medical records. You may want to refer to the explanation we provided in the denial notice you were issued.

Signature of person requesting the appeal (the member, or the member's physician or representative:

_____ **Date:** _____

Clover Health is a Preferred Provider Organization (PPO) plan and a Health Maintenance Organization (HMO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal.