Member Appeal Form

Clear Form

INSTRUCTIONS

Please complete this form in its entirety to ensure accurate and timely processing of your appeal; incomplete information may delay the review and resolution of your appeal. Please be sure to include all relevant information with this form. If you are submitting this appeal on behalf of another person who is age 18 or over, a signed Designation of Personal Representative for Claim Appeal may be required to process your appeal.

MEMBER / PATIENT INFORMATION

Last Name	*First Name*	*Member ID#*	
Mailing Address	*City*	*ST*	*ZIP Code*
Date of Birth	*Email Address*	*Primary Phone#*	

SUBMITTER INFORMATION

Name of Person Submitting Appeal	*Relationship to Member*		
Mailing Address	*City*	*ST*	*ZIP Code*
Email Address	*Primary Phone#*		

APPEAL INFORMATION

I am appealing a denial for:

- ☐ Use of a non-network provider
- ☐ A payment amount
- ☐ A deductible amount
- ☐ Other:
- ☐ Service not covered
- ☐ Not medically necessary
- ☐ Prior authorization / precertification not obtained

Claim#(s) (if applicable)	*Date(s) of Service*

Please explain your reasons for submitting this appeal *(attach additional pages if necessary)*:

PLEASE SUBMIT YOUR APPEAL WITH SUPPORTING DOCUMENTATION TO:

HPI
Member Appeals Department
P.O. Box 5199
Westborough, MA 01581
Fax: 508-329-4812