APPEAL FORM

Please return completed form to:
BridgeSpan Health Company
Attn: BridgeSpan Level 1 Member Appeals
PO Box 4208
Portland, OR 97208-4208
or via fax at 1 (888) 496-1542

Contact the phone number on the back of your member identification card for assistance with filling out this form.

Patient Name	Date of Birth (mm/dd/yyyy)	Phone Number (xxx) xxx-xxxx
Address	City, State, ZIP Code	E-mail Address (optional) Email address
Identification Number	Group Number	Today's Date (mm/dd/yyyy)
Doctor/Hospital Name	Date(s) of Service or Incident	
Claim Numbers (if available)		

Note: 1) Appeals must be received within 180 days from the date of initial adverse determination.

2) If you are initiating an appeal on behalf of another person who is not a minor, BridgeSpan Health Company (BridgeSpan) must also receive a completed HIPAA authorization form, signed by that person, which can be found on the **bridgespanhealth.com** website.

Please explain the problem. Include background, time frames, and the names of anyone else you have spoken with to try and resolve the problem, any supporting documentation, and your expectations or suggestions for resolution.

List any supporting documentation attached to this form _____

_____

We need your permission to authorize BridgeSpan to request any medical records needed to answer your appeal. This includes information about alcohol or drug abuse, mental health, AIDS or HIV virus, if applicable. This authorization begins today and remains in effect so long as your appeal is being reviewed. You will receive an acknowledgment letter for this appeal with information about the appeals process.

▶ _____ (mm/dd/yyyy)

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE *
(Patient's parent/guardian may sign if patient is a minor child)

TODAY'S DATE

THIS SECTION TO BE COMPLETED BY OFFICE STAFF	Did the member fax or mail in supporting documentation? Check box if Yes. ☐ Did the member provide this authorization verbally? Check box if Yes. ☐

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