Molina Healthcare of New York, Inc.

Appeal request form

For services being reduced, suspended, or stopped

Mail to:	Fax to: MNY- (315) 234-9812				
Molina Healthcare of New York, Inc. 2900 Exterior St. Suite 202 Bronx, NY 10463		Today's date:			
Deadline:					
If you want to keep you ask within 10 calendar takes effect, whicheve services you got while	days of the date or is later. (If you los	of this notic se your app	ce, or by the	date the c	lecision
 The last day to ask for 	a Plan Appeal to I	keep your s	ervices the	same is [].
 You have a total of 60 Plan Appeal. The last d If you want a Plan Appeal 	ay to ask for a Pla	ın Appeal fo	or this decis		or a].
Enrollee information:					
Name:] []			
Enrollee ID:]				
Address: [][,]
Home Phone: []	Ce	ell Phone: []
Plan Reference Number:	[]			
Service being reduced, s	uspended or stop	ped: []	
I think the plan's decision is v	vrong because:				



I do <u>NOT</u> want my services to stay the same while my Plan Appeal is being decided.				
☐ I request a Fast Track Appeal because a delay could harm my health.				
\square I enclosed additional documents for review during the appeal.				
☐ I would like to give information in person.				
☐ I want someone to ask for a Plan Appeal for me:				
° Have you authorized this person with Molina before? YES □ NO □				
 Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES □ NO □ 				
Requester (person asking for me):				
Name: E- mail:	_			
Address:				
City: State: Zip Code:				
Phone #: ()Fax #: ()				
Enrollee signature: Date:				
Requester signature: Date:				

Check all that apply:

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

