brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

Appeal Form

This form is for your use when filing an appeal about the plan's decision to not cover medical care or prescription drugs. If you have any questions, please feel free to call the Brand New Day Customer Service Call Center at **866-255-4795** or TTY/TDD **866-321-5955,** *8 a.m. to 8 p.m. 7 days a week (February 15th to September 30th open 8 a.m. to 8 p.m. Monday – Friday.)*

Please Print or Type the Following Information about yourself:

Member Name: _____**Member ID:** _____
Address: _____
Telephone: _____

You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to make an appeal. There may be someone who is already legally authorized to act as your representative under State law. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form or go to our website at www.bndhmo.com. Or complete the information below about the person you are naming to act for you. **We cannot start review of complaints from someone other than you unless we have the completed Appointment of Representative form or other proof of legal authorization for someone to act for you.**

Please Print or Type the Following Information about your Representative:
I appoint the following person to act for me for this appeal:
Representative's Name: _____ Representative's Address: _____ Representative's Telephone: _____
Relationship to member: _____
Signature of member: _____ Date: _____
Signature of Representative: _____ Date: _____

Information about your appeal:
Use the space below to help describe your appeal. You may provide additional evidence with this form**:**
Item or service you wish to appeal: _____
Drug name: _____ Dosage/Strength _____
Provider Name: _____
Date(s)_____ Claim amount: _____

Claim number: _____

Describe why you want to appeal:
_____
_____
_____
_____
_____
Signature of member: _____ Date: _____

Mail completed form to Brand New Day, Attn: Appeals and Grievances, 5455 Garden Grove Blvd., Suite 500, Westminster, CA 92683 or **Fax:** 1-657-400-1217
H0838_Member Appeal form_Accepted