VirginiaPremier™
Powered by VCU Health

Appeal Request Form

Name: (First Name, Middle Initial, Last Name):		Date of Birth:
Street Address or P.O. Box, City, State, ZIP:		
Member ID Number:	Main Phone Number:	Other Phone Number:
Doctor's Name:		Doctor's Phone Number:

I am appealing the action of Virginia Premier Health Plan, Inc. (Virginia Premier).

The date on the letter that I was told about Virginia Premier's decision is:

_____/_____/_____

The person who spoke or wrote to me telling me about the action that I am appealing is:

Name: _____Title: _____

Virginia Premier has (check the space that best matches what your appeal):

( ) Denied a service I asked for

( ) Stopped or ended a service I was getting

( ) Denied all or part of the cost for a service that Virginia Premier covers

( ) Other (please explain) _____

The service or drug you are appealing: _____

You are asking for an appeal because:

_____

_____

_____

IMPORTANT: Please send a copy of the notice or letter about the action you are appealing. If you are the not the member, please be aware that Virginia Premier cannot move forward with this appeal until the member's written consent is received. Please send in supporting medical records, doctor's letters or other information that explains why Virginia Premier should approve your appeal.

If you have a representative, list their information here (you do not need to have a representative):

Name: _____

Address: _____

Phone Number: _____

Signature of person making the appeal: _____ Date: _____

Signature of the Member: _____ Date: _____