

Appeal and Complaint Submission 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:
<p>I am appealing and/or complaining about 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:</p> <p>____/____/____</p> <p>The person who spoke or wrote to me telling me about the action that I am appealing and/or complaining about is:</p> <p>Name: _____ Title: _____</p>		
<p>Virginia Premier has (check the space that best matches what your appeal and/or complaint):</p> <p>() Denied a service I asked for</p> <p>() Stopped or ended a service I was getting</p> <p>() Denied all or part of the cost for a service that Virginia Premier covers</p> <p>() Other (please explain) _____</p> <p>The service or drug you are appealing: _____</p>		
<p>You are asking for an appeal and/or filing a complaint because:</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>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 and/or complaint 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.</p>		
<p>If you have a representative, list their information here (you do not need to have a representative):</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone Number: _____</p>		
Signature of person making the appeal and/or complaint: _____		Date: _____
Signature of the Member: _____		Date: _____