Ohio Medicaid Managed Care Entity

Member Standardized Appeal Form

Complete Sections I and II of this form entirely, describe the issue(s) in as much detail as possible, and submit the completed form to the appropriate managed care entity (MCE). To ensure a decision can be made by the MCE, the following documentation should be submitted with the form:

- Attach *copies* of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

Section I – Member Information	
Member Name	**Date of Birth** (mm/dd/yyyy)
Member ID Number	**Member Phone Number**
Member Address	
Date of Request (mm/dd/yyyy)	**Request Type** ☐ Grievance/Complaint ☐ Appeal ☐ Expedited Appeal

Section II – Description of Specific Issue *(Please state all details relating to your request including names, dates, and places. Attach another sheet of paper to this form if more space is needed)*	
By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.	
Member's Signature	**Date** (mm/dd/yyyy)
Member's Authorized Representative Name (if applicable)	**Authorized Representative Signature** (if applicable)

Contact and Submission Information
<insert all MCE contact information here (fax or email information to be gathered from MCEs at later date>