Member Appeal Request Form

As a member of Colorado Community Health Alliance (CCHA), we manage your Health First Colorado (Colorado's Medicaid Program) behavioral health benefits and services. If you do not agree with the decision we made about your behavioral health benefits or services in the Notice of Adverse Benefit Determination letter you received, you or someone you designate as your representative can file an appeal.

Steps to ask for an appeal:

1. Fill out this form.
2. Sign this form. We must have you or your designated representative's signature on this form to process your appeal.
3. If you would like to have a family member, friend, advocate, or provider represent you for this appeal, this person should also fill out the Designated Client Representative section of this form.
4. Mail or fax this form to:

   CCHA Central Appeals Processing
   P.O. Box 62429
   Virginia Beach, VA 23466-2429
   Fax: 844-452-8067

If you requested an appeal by phone, you must fill out, sign, and mail or fax this form to us within 10 business days of your appeal request in order for us to process your appeal.

Member name:_____

Member date of birth:_____

Parent's or guardian's name (if service is for a child):_____

Health First Colorado member ID #:_____

Reference number (on your Notice of Adverse Benefit Determination):_____

Name of provider who wants to give or who gave you the service:_____

Why you are asking for an appeal:_____

_____

_____

_____

_____

Signature:_____ **Date**:_____
Member, Parent, Legal Guardian or Designated Representative

Designated Client Representative Consent

If you would like someone to serve as your representative during your appeal, you or your parent or legal guardian must provide written consent to CCHA. Your representative can be a family member, friend, advocate or provider. By completing this section, you agree to the following:

- Your representative may see your private health information
- Your health information may be at risk for being re-disclosed
- Your chosen representative will be your only representative during this appeal
- If you want someone to serve as your representative in future appeals, you will have to fill this form out again
- If you decide to not complete this form, your decision will not impact your appeal or benefits in any way
- If you are a minor child 15 years of age or older, you must sign this form to have someone act as your representative. Your parent or legal guardian cannot sign this form for you if you are 15 years of age or older.

Member, Parent or Legal Guardian's name (if applicable): _____

Member signature: _____ Date: _____

Designated client representative's name: _____

Representative's signature: _____Date: _____

Representative's phone number: _____

Representative's street address:

_____

_____

City State ZIP

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-855-627-4685 (TTY 711).

¿Necesita ayuda con el cuidado de la salud, para hablar con nosotros o para leer lo que le enviamos? Le ofrecemos nuestros materiales en otros idiomas y formatos sin costo alguno. Llame a nuestra línea gratuita al 1-855-627-4685 (TTY 711).

Colorado Community Health Alliance (CCHA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. For more information, visit CCHAcares.com/non-discrimination-notice.