APPEAL REQUEST FORM

Fecha de recibo: / / mes, día, año

SECTION A: PERSONAL INFORMATION OF THE APPELANT		
Name (PRINT)	Telephone Number	Contract Number
Address	Date Case Filed	Provider Number (if applicable)
	PMG Number	Primary Physician Provider (if applicable)

SECTION B: **APPEAL FILED DUE TO:**		
Name	Contract Number	Primary Physician Provider (if applicable)

SECTION C: DESCRIPTION OF THE EVENTS RELATED TO THE APPEAL (Include documents that support your case like: study results, medical order or any other document needed in order to work your case efficiently) You can continue in a new page if more space is needed.
Provider, Member or Representative's Signature Witness Signature (if applicable)

12-20-039E

Customer Service Representative's Name

Customer Service Representative's Signature

**** Complete all the applicable fields and sign this form, you can bring it to a Regional Office near your home, send by regular mail, fax, or email (details below).**

INSTRUCTIONS: How to ask for a grievance or an appeal with PSM?

Step 1: You, your representative, or your physician [*provider*] acting on your behalf (authorized in written by you) can request a grievance or an appeal. Your *written* request must include:

- Your name, member ID, contract number, and address
- Reasons for your grievance or appeal
- Any evidence you want us to review, such as medical records, provider's letters, or other information that explains why you need the item or service. Ask your physician for this information.

How to Submit your Complaint, Grievance or Appeal:

Please submit this completed form by mail, in person, or fax:

By Mail or In Person:
Attention: PSM-GHP Grievances & Appeals Department
P.O. Box 364668, San Juan, P.R. 00936

By fax:
Attention: PSM Grievances & Appeals Department
787-332-0928

You can use the attached form or you may write a letter including all the details.

This form is available in our website www.menonitavital.com.

This format is available in alternative formats, such as large print, braille, or audio.

This form is also available in other languages, and PSM will provide oral interpretation services into any language other than English, if needed. Such translation is at no cost to you.

12-20-039E

If you need more information, or assistance to file a Complaint, Grievance or Appeal, please call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). Available Monday through Friday from 7:00 AM to 7:00 PM. This phone call is free. Upon request, interpreter services are also available.

You also have a right to present grievances before at the Patient's Advocate Office (OPP) or in the Puerto Rico Health Insurance Administration (ASES).

Contact information for the OPP:
Telephone: 787-977-1100 (Metro Area) 1-800-981-0031 (toll free)
Fax: 787-977-0915
Contact information for ASES:
Telephone: 787-474-3300 (Metro Area) 1-800-981-2737 (toll free) Fax: 787-474-3348

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 1-866-600-4753 (TTY: 1-844-726-3345)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-600-4753 (TTY: 1-844-726-3345). al 1-866-600-4753 (TTY: 1-844-726-3345).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電（TTY：1-866-600-4753 ; 1-844-726-3345）。

PSM cumple con las leyes estatales y federales aplicables de derechos civiles y no discrimina por razón de raza, edad, color, origen de nacionalidad, discapacidad o sexo.

Documento puede estar disponible en formatos alternativos como letra grande, audio u otros idiomas. Si necesita recibir estos servicios, llame al 1-866-600-4753 y 1-844-726-3345 TTY (audioimpedidos).

12-20-039E

PLAN DE SALUD MENONITA
1-866-600-4753 (libre de cargos) · 1-844-726-3345 TTY (audioimpedidos)
PO Box 364668, San Juan, PR 00936 · www.MenonitaVital.com