Request for a Reconsideration (Appeal) Form
For Inpatient and/or Outpatient Services

Member Information		
Member ID Number	Telephone No: ( ) -	
Last Name	First	MI
Street Address:		
City:	State/ Zip Code:	Date of Birth:

Person appealing: ☐ Beneficiary ☐ Provider ☐ Authorized Representative

Last Name	First	MI
Street Address:		
City:	State/ Zip Code:	Relationship to Member:

Date the Item or Service was Provided:

Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 60 days ago, include your reason for the late filing.)

I do not agree with the determination decision because:

Additional Information MoreCare should consider:

☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it.

☐ I do not have evidence to submit.

Signature _____ Date _____

Authorized Representatives must complete an Authorized Representative form and submit it with this appeal form or have one on record with the health plan.

Mail or Fax this Request to:
MoreCare
Attn: Grievance and Appeals
P.O. Box 21994
Eagan, MN 55121
Or via Fax: 1-888-345-9110