KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington
Member Appeals
P.O. Box 34593
Seattle, WA 98124-1593
Phone: 1-866-458-5479
Fax: 206-630-1859

Member Appeal Request

Date: **Time:**	**Member Name:**
Member ID Number:	**Requested By (if not member):** **Relation To Member:**
Phone Number (of person requesting appeal):	**Email Address:** **OK to use email? ☐ Yes ☐ No**
Address (of person requesting appeal):	
This request is in regard to a member* denial for coverage of the following service/s:	
Referred by (self or physician name):	
If there are other providers we should get records from, please provide names:	
Check one of the following: ☐ **Authorize payment for services currently being received at (place of service)** ☐ **Authorize payment for denied services received on (date) _____ at (facility name) _____ from (provider name)_____.** ☐ **Authorize payment at a different cost share level.** ☐ **Pre-authorize payment for services that were denied. Provide date service is scheduled_____.**	
Why do you think Kaiser Foundation Health Plan of Washington ("Kaiser Permanente") should authorize these services? Check all that apply. ☐ **It is a covered service.** ☐ **There are no Kaiser Permanente providers who can provide this service.** ☐ **It is medically necessary and is covered when medically necessary.** ☐ **I was led to believe this service was covered in full or at a different cost share.** ☐ **My provider told me to get this service.** ☐ **I was dissatisfied with the service I received and do not feel as though I should pay for it.**	

Please add any additional information which supports your belief that Kaiser Permanente should authorize payment for these services:

You may fax or mail this form with attachments. See contact information at top of page. Attach denial documents and other records or documents that support your request.

If you are submitting this request on behalf of the member, you must complete and return to Kaiser Permanente Member Appeals a copy of the following forms:

- ✓ Release of Information
- ✓ Appointment of Representative
- ✓ Specially Protected Confidential Release (if request is for sexual reproduction or disease, mental health, or chemical dependency)

If the member is unable to sign the Appointment of Representation or Release of Information forms then you must send Kaiser Permanente Member Appeals:

- ✓ Health Care and/or Financial Dependent Power of Attorney form stipulating you are currently authorized to appeal on behalf of the member.

If you are the treating provider submitting this request on behalf of a member, you must submit an Appointment of Representative form signed by you and the member, and an Authorization to Release Health Care Information form signed by the member.

* If the denial document states the payment is the **provider's** responsibility, then the provider must submit a reconsideration request (in writing) to the Provider Assistance Unit. The member may not appeal on behalf of the provider.