



10680 Treena Street, Stop 5 ■ San Diego, CA 92131 ■ (800) 788-2949 ■ www.medimpact.com

APPEAL FORM

To initiate an appeal, complete and submit this form to MedImpact's Appeal Coordinator at the address listed above. Or, fax it to the Appeal Coordinator at (858) 790 6060. **Attach a copy of the denial letter to the appeal.**

Date: _____ PA Reference # (found on denial letter): _____

Member Information

Name: _____ DOB: ____/____/____
First Name MI Last Name

Group/Health Plan Name: _____ Group/Health Plan Id #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Physician Information (name and phone number are required)

Name: _____ Physician ID#: _____
First Name Last Name

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ DEA#: _____

Appeal Information /Description of Appeal (Attach a copy of the denial letter to your appeal)

Date drug was denied: _____ Drug name, strength, and duration denied: _____

Provide a detail description of the reason for this appeal (attached additional sheets if necessary): _____

Authorized Representative Information

If Someone Other Than The Member Is Filing This Appeal, Please Provide The Following Information:

Name: _____ Relationship to Member: _____
First and Last

Address: _____ City: _____ State: _____ Zip: _____

Daytime Telephone: (____) _____ - _____

I Hereby Attest That The Above Information Is True:

Member's Signature _____ Date _____

Representative's Signature (if one has been assigned) _____ Date _____