MCS Classicare (HMO)

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# MCS CLASSICARE APPEALS REQUEST FORM

## OFFICIAL USE

**Referral Source**

| Call Center | Service Center | Mail | e-mail | Ethics Point | Fax | Phone Call (Not received through the Call Center) | OPP/SHIP | Referred by Compliance | Other (Please Specify): |
|---|---|---|---|---|---|---|---|---|---|

**Reserved for the referring Unit/ Department**
**Please stamp the designated area with the date and time**

**Name of the employee who is referring the case**

**Position of the employee who is referring the case**

**Signature of the employee who is referring the case**

**Reserved for Grievances and Appeals Unit**
**Please stamp the designated area with the date and time**

## ENROLLEE INFORMATION

| First Last Name | Second Last Name | Name & Initial | Contract Number | Telephone | Filing Date |
|---|---|---|---|---|---|
| | | | | | |

Postal Address

| Urbanization/ Ward | Street | Number or P.O. Box | City | State | Zip Code |
|---|---|---|---|---|---|
| | | | | | |

| Service: | Date the service was or will be provided: | Complete Name/ Provider's NPI |
|---|---|---|
| | | |

## DESCRIPTION OF THE FACTS

Indicate how the events you allege occurred:

## CERTIFICATION

I CERTIFY THAT THIS DOCUMENT IS MY APPEAL AND CONTAINS, IN MY OWN WORDS, THE TRUTH ABOUT THE EVENTS. I FURTHER CERTIFY THAT I HAVE BEEN ADVISED OF FRAUD IN THE APPEALS FILING PROCESS.

Signature of enrollee or legal representative

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