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Amerigroup Medicaid appeal request form

To ask for a health plan appeal, you can call us at **800-600-4441 (TTY 711)**, Monday−Friday 7 a.m. to 6 p.m. Central time/**STAR Kids 844-756-4600 (TTY 711)**, Monday−Friday 8 a.m. to 6 p.m. Central time, or you can fill out this form and mail or fax it to us.

Mail: Amerigroup
PO Box 62429
Virginia Beach, VA 23466-2429
Fax: 877-881-1305

You must request an appeal by 60 days from the date the notice is mailed.

If you want to continue your services during your appeal, you must make your request by **the date that is the later of the following: 10 days from the date the notice is mailed or the date services will change**.

Mark the appeal you want:
Only select one.
☐ Health plan appeal
☐ Emergency health plan appeal*
* Emergency health plan appeals should only be requested if you believe your health will be seriously harmed by waiting for your health plan appeal decision.

Reference number: _____

Do you want your services to continue? ☐ Yes ☐ No

You must request for your services to continue by **the date that is the later of the following: 10 days from the date the notice is mailed or the date services will change**.

You can make this request by phone. Call us at **800-600-4441 (TTY 711)/STAR Kids 844-756-4600 (TTY 711)** if you think this form will not reach us by mail before the deadline.

Your personal information*

Member name:	Parent or authorized representative:
Member Medicaid ID and subscriber number:	Preferred phone number:

4573684 1015881TXMENAGP 01/22
5340327 1015881TXMENAGP 04/22

* If any of your contact information has changed, call the enrollment broker at **800-964-2777** or Amerigroup at **800-600-4441 (TTY 711)/STAR Kids 844-756-4600 (TTY 711)**.

Your authorized representative's or parent's information

You can represent yourself. If you would like someone to represent you, such as, parent, relative, or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Reason for the appeal

This section is optional. You can fill it out to tell us about your services under appeal and why you think they're needed.

Services under appeal:
Why you need them:

Sign this form:

By signing this form, you or your authorized representative are requesting an appeal and giving your health plan, Amerigroup, authorization to get your medical records and to contact your appeal representative if you listed one.

_____

Member/authorized representative signature

_____

Printed name Date

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.