Member Appeal Form

If you have a complaint or grievance, please complete and submit this form to the Oklahoma Health Care Authority (OHCA) to initiate the Appeals Process. The completed form must be received by OHCA **within thirty (30) days of the triggering event** (the date on which the event you are appealing occurred).

Failure to complete and return this form within 30 days can result in a dismissal or denial of your appeal.

Please provide all requested information, including a complete explanation of the problem/issue. Include the name(s) of any OHCA personnel with whom you have dealt and the dates on which specific events occurred. Use additional paper if necessary. Attach copies of any supporting documentation you would like to be considered.

Member Information

Member Name: ______________________________ Member ID: ____________

Member Mailing Address: ______________________________

City: ______________________ State: __________ Zip Code: ____________

Phone Number: ______________________ Email Address: ______________________

Date of Triggering Event: ______________________________

Member's Guardian (if applicable): ____________________ Guardian Phone: ____________

Authorized Representative (if any)

I, *____________________ authorize ____________________ to serve as my representative in connection with this appeal. I authorize my representative to present evidence, to obtain information about my appeal, and to receive notices in connection with my appeal. I understand that my personal health information (PHI) may be disclosed to my Representative. I understand that my PHI may include information about drug or alcohol disorders or treatment, mental health disorders or treatment, and communicable or non-communicable diseases. By signing this form, I am authorizing disclosure of this information. My representative will be available to represent me on the date and time of the appeal hearing as set by the Oklahoma Health Care Authority. I do not have a legally appointed Guardian, or my legally appointed Guardian hereby consents to this authorization.*

____
Member Signature Date

____
Authorized Representative Signature Date

Mailing Address: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

Please tell us about your request in the space below. Be as specific as possible and whenever possible, give the date(s) on which the event occurred. Please include what you would like OHCA to do about this issue. (*If you need more space, use another sheet of paper).*

IMPORTANT NOTICE FOR RECIPIENTS OF SOONERCARE BENEFITS OR SERVICES WHOSE BENEFITS OR SERVICES WERE DISCONTINUED OR REDUCED:

You must request an appeal and your appeal must be **received** by the Docket Clerk within 10 calendar days of the date on the notice you received if you want your benefits to continue until your appeal has been decided. Otherwise, your appeal must be filed within 30 calendar days of the date of your notice.

IMPORTANT: If you choose to keep receiving services while your appeal is being considered and your appeal decision is not in your favor, you may have to pay for the services you received.

If you file your appeal within 10 days of the date on your notice and you do **NOT** want services or benefits to be continued while your appeal is pending, check the box below:

_________ I **do not** want services or benefits to continue while my appeal is being decided.

____   ______________________________

Member Signature   **Date**

Please send this form to:

Oklahoma Health Care Authority
Grievance Docket Clerk
P.O. Drawer 18497
Oklahoma City, OK 73154-0497

Fax: 405-530-3444
Phone: 405-522-7217
Email: docketclerk@okhca.org