



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

APPEAL/GRIEVANCE FORM

To initiate an appeal/grievance, 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/Grievance (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/grievance (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 _____