Appeal form

This form is to help you file an appeal. You can fill out the form and send it to us or call Member Services at **1-800-962-8074** to file an appeal.

Health Plan of Nevada
Attn: Customer Response and Resolution Department
P.O. Box 14865
Las Vegas, NV 89145

Your request to file an appeal must be received within 60 days from the date on the denial letter.

Please print

Member Name ____

Member ID ____

Address ____

City ______________________________ State__________ ZIP Code__________

Telephone Number ____

Description of Denied Service____

Date of Denial ____

Share information you would like considered in your appeal and why you feel the plan should approve your request:

Please attach any evidence you would like us to consider during the appeal process.

Please complete the Appointment of an Authorized Representative form.

Authorized Representative (if you have one) ______________________________

Member's Signature ______________________________ Date__________________