Medical Appeal Request

YouthCare HealthChoice Illinois

If you would like to appeal the decision we have made, you can write a letter or fill out this form and send it to us within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination for a regular appeal. You can also call us within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination. If you or someone acting on your behalf call us first, you must still send a letter or this form to us within thirty (30) calendar days after you called us.

If you or your doctor think your life or health is in immediate danger because of the decision in the Notice of Adverse Benefit Determination letter, you or the doctor acting on your behalf can ask for a quick (**expedited**) appeal by calling us. If you call us to request a quick appeal, you do not need to send YouthCare this form.

If you want help filling out this form, please call (844)-289-2264 (TTY: 711).

Date _____

Who is requesting this appeal? (check one)

☐ Member ☐ Someone other than Member

Name: _____

Relationship to Member: _____

MEMBER INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MI: _____

Member Address: _____

City: _____ State: _____ Zip: _____

Member Phone #: _____

Member Email: _____

Reason for Appeal: _____

_____

For Expedited Appeal Requests:

HEALTHCARE PROVIDER INFORMATION:

Provider's Name: _____

Provider's Address: _____

City: _____ State: _____ Zip: _____

Name of Contact at Provider's Office: _____

Provider's Phone #: _____ Provider's Fax #: _____

Reason for Appeal: _____

_____

*Please attach any medical information that will help us to understand your medical condition and your appeal.
Send it to:

YouthCare
Attn: G&A Department
P.O. Box 733
Elk Grove Village, IL 60009-0733
Fax: 833-920-1747
Email: ILYouthCareG&A@centene.com