COORDINATED SYSTEM OF CARE

Magellan HEALTHCARE SM

LA CSoC Member Appeal Form

(Complete this form only if you want to appeal a decision Magellan made on a request for services.)

Date(s) of Services you are appealing:	MM/DD/YYYY:	Thru:
Provider Name:		

Your (member's) information

Member's Medicaid ID Number:		
Member's Name (First, MI, Last)		
Street Address:		
City:	State:	Zip Code:

Member Phone Number:	Area Code:	Phone Number:

Tell us why you do not agree with our decision and filing the appeal

(Support your appeal by sending us any documents with this form. This includes records or letters from your provider.)

Authorized Representative Information

You may name someone to help and act for you in filing your appeal (called your Authorized Representative). This person may be your provider. If you choose someone, please tell us below. We will send you an *Authorized Use and Disclosure Form* to complete and return. This will allow us to send this person the same information we send you on the appeal until you tell us to stop.

Representative Name (First, MI, Last):		
Street Address:		
City:	State:	Zip Code:

Representative Phone Number:	Area Code:	Phone Number:
Relationship to Member:		

You (the member) need to sign this form

Signed:	Date:

Mail this form to: ***Magellan of Louisiana*** ***Attn: Appeals Department*** ***P.O. Box 83680*** ***Baton Rouge, LA 70884-3680***	***Call us if you have questions or need help with completing this form.*** ***(800) 424-4489*** ***TTY: (800) 846-5277***