Request for Reconsideration of Denial of Medical Coverage or Payment

MASS ADVANTAGE

Because we, Mass Advantage, denied your request, you have the right to ask us for a reconsideration of our decision. You have 60 days from the date of denial to ask us to reconsider our decision. If you have missed this deadline, you may still submit this form and ask for an extension. Your written appeal request must include the reason why you could not file the request for reconsideration within 60 days of the denial notification.

Contact Information

This form may be sent to us by fax to 888-656-7783 or mailed to:
Mass Advantage, ATTN: MPD - 1100UR, P.O. Box 64806, St. Paul, MN 55164-0811.

You may also ask us for an appeal through our website at www.massadvantage.com. Expedited appeal requests can be made by phone at either 844-918-0114 (HMO) or 844-915-0234 (PPO). (TTY: 711).

1 Who May Make a Request

You want another individual (such as a family member or friend) to request a reconsideration for you, that individual must be your representative. You can appoint an individual to act on your behalf by providing us with a completed Authorization of Representative Form, CMS-1696 form, or other legal documentation (such as a durable power of attorney or guardianship) that shows the authority of your representative. If you have any additional questions, feel free to contact us by phone at the numbers listed above.

2 Enrollee's Information

Enrollee's Name

Date of Birth (mm/dd/yyyy) | Enrollee's Member ID Number

Enrollee's Address (include Apt. #)

City | State | Zip

Phone Number | Email

3 Requester Information

Complete the following section ONLY if the person making this request is not the enrollee, and include the documentation outlined on Page 1.

Requester's Name | Phone

Requester's Relationship to Enrollee

Address

City | State | Zip

4 Item to be Reconsidered

Medical Service, Item, or Part B Drug to be reconsidered:

Have you already received or paid for the medical service, item or Part B Drug?

☐ Yes ☐ No

What type of appeal are you requesting (timeframes explained below)?

☐ Standard ☐ Fast

If you are requesting a Fast Appeal, please explain why you need one (if you have a supporting statement from your provider, please attach it to this request):

Important Note: Fast Appeals

If you or your provider believe that waiting 30 calendar days for a standard reconsideration, or 7 calendar days for a Part B drug reconsideration, could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your provider indicates that waiting the standard timeframe could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your provider's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a medical service/item you already received or appealing a payment decision for a service already received.

5 Provider's Information

Provider Name

Provider Address

City | State | Zip

Contact Name

Phone Number | Fax

5 Reason for Appeal

Please explain your reasons for appealing. Attach additional pages, if necessary. Include any additional information you believe may help your case, such as a statement from your provider, relevant medical records, doctors' letters, or other information that explains why you need the medical service/item/Part B drug. You may want to refer to the explanation we provided in the denial letter and have your provider address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents.

6 Signature of Person Requesting the Appeal

Signature | Date