Request for Reconsideration of Denial of Medical Coverage or Payment

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. This form may be sent to us by mail or fax:

Address:
Mass Advantage
P.O. Box 1285
Maryland Heights, MO 63043

Fax Number:
888-656-7783

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).

Who May Make a Request: If 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.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State_____ Zip Code _____

Phone _____ Enrollee's Member ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee, and include the documentation outlined above:

Requestor's Name _____ Phone _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State_____ Zip Code _____

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):

_____
_____
_____
_____

Provider's Information

Provider's Name _____

Provider's Address _____

City _____ State_____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

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.

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.

_____
_____
_____

Signature of person requesting the appeal:

_____ Date _____