701 NE 10th ST | Ste. 300 | Oklahoma City, OK| 73104-5403

Appeal Request Form

Name of Person Filing Appeal: ____

Patient: ____ Relationship: ________________________

Service you are appealing: ____

Describe why you disagree with the decision (you may attach additional information, such as a physician's letter, bills, medical records, or any other documents to support your claim).

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

APPOINTMENT OF AUTHORIZED REPRESENTATIVE
(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize ______________________________________ to pursue my appeal on my behalf.

____ ___________________________

Signature of Patient (If 18 years or older) Date

____ ___________________________

Signature of Authorized Representative* Date

MAGR 08/2014

*(Parent, Guardian, Conservator or Other – Please Specify)

Address of Authorized Representative: ____

City: _______ ______________________________________ State: ____________ Zip: ____________

Phone # Daytime (_____)_______________________ Evening (_____)_________________________

Mail this form and a copy of your denial notice to:

GlobalHealth, Inc.
ATTN: Appeals
PO Box 2393
Oklahoma City, OK 73101-2393

Be sure to keep copies of this form, your denial notice, and all documents and correspondence related to this claim for your records.

Para los miembros que hablan español:
Si usted no entiende los contenidos de esta carta, por favor llame a Servicios para los Miembros al <<1-877-280-5600>> y alguien le ayudara.