Member Appeal Request Form

Colorado Community Health Alliance (CCHA) manages your Health First Colorado (Colorado's Medicaid Program) behavioral health benefits and services. If you do not agree with the decision we made about your behavioral health benefits or services, which is provided in the Notice of Adverse Benefit Determination letter you received, then you or someone you designate as your representative can file an appeal.

Steps to ask for an appeal using this form:

1. Fill out the form.
2. If you would like to have a family member, friend, advocate, or provider represent you for this appeal, this person should fill out the Designated Client Representative section of this form. You and your designated client representative must sign this section.
3. Mail, fax, or email the form to:

   CCHA Central Appeals Processing
   P.O. Box 62429
   Virginia Beach, VA 23466-2429
   Fax: 1-877-376-3194
   Email: BHAppealsIntake@anthem.com

You are not required to complete this form to request an appeal with CCHA. The Notice of Benefit Determination letter you received provides information on other ways to submit an appeal to CCHA.

Member name:_____

Member date of birth:_____

Parent's or guardian's name (if service is for a child):_____

Health First Colorado member ID #:_____

Reference number (on your Notice of Adverse Benefit Determination):_____

Name of the provider who wants to give or who gave you the service:_____

In Colorado, Medicaid is called Health First Colorado. Every Health First Colorado member belongs to a regional organization that manages their physical and behavioral health care. Colorado Community Health Alliance is a regional organization and supports a network of providers to make sure members can access care in a coordinated way.

Health First COLORADO
Colorado's Medicaid Program

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Why you are asking for an appeal:_____

_____

_____

_____

_____

Signature:_____ **Date**:_____
Member, parent, legal guardian or designated representative

Designated Client Representative Consent

If you would like someone to serve as your representative during your appeal, you or your parent or legal guardian must provide written consent to CCHA. Your representative can be a family member, friend, advocate, or provider. By completing this section, you agree to the following:

- Your representative may see your private health information.
- Your health information may be at risk of being re-disclosed.
- Your chosen representative will be your only representative during this appeal.
- If you want someone to serve as your representative in future appeals, you will have to fill this form out again.
- If you decide to not complete this form, your decision will not impact your appeal or benefits in any way.
- If you are a minor child 15 years of age or older, you must sign this form to have someone act as your representative. Your parent or legal guardian cannot sign this form for you if you are 15 years of age or older.

Member, parent or legal guardian's name (if applicable): _____

Member signature: _____ Date: _____

Designated client representative's name: _____

Representative's signature: _____ Date: _____

Representative's phone number: _____

Representative's street address:

_____

_____

City State ZIP

If you need this information in another format or language, please contact CCHA Member Support Services at 1-855-627-4685 (TTY 711).

Si necesita esta información en otro formato o idioma, comuníquese con los Servicios de ayuda para miembros de CCHA al 1-855-627-4685 (TTY 711).

Colorado Community Health Alliance (CCHA) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. For more information, visit CCHAcares.com/non-discrimination-notice.