Medicare Appeal Form

Because we, Farm Bureau Health Plans, denied your request for coverage you have the right to ask us for a reconsideration (appeal) of our decision. You or your authorized representative must submit this request within 60 calendar days from the date of the event occurrence or a denial notification letter. Farm Bureau requires appeals to be submitted in writing. This form may be sent to us by mail or fax:

Address:
Farm Bureau Health Plans
Attn: Appeals
P.O. Box 240
Columbia, TN 38402

Fax Number:
855-632-4762

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Expedited appeal requests can be made by phone at (833) 999-0103. Our hours of operation are 8 a.m. to 8 p.m. local time, 7 days a week October 1 – March 31 during which time our automated phone system may answer your call on Thanksgiving and Christmas day. April 1 – September 30 our hours are 8 a.m. to 8 p.m., Monday – Friday. Our automated phone system may answer your call on weekends and federal holidays. TTY users should call 711.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. To appoint a representative, complete the Appoint of Representative Form (CMS 1696 Form) with your appeal.

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:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

If you wish to file an appeal to a previously denied service or claim, please provide the information requested below.

Is this in regards to a denied claim? ☐ Yes ☐No

If "Yes": Claim #: _____
Date of Service: _____
Provider Name: _____

Is this in regards to a denied medical service or treatment? ☐ Yes ☐No

If "Yes", please provide the date of the Denial Letter: _____

Please describe the reason and a brief description of you appeal. You may use additional pages if necessary and/or both supporting documentation.

_____

Signature of person requesting the appeal (the enrollee or the representative):

_____ Date: _____

Farm Bureau Health Plans is a Medicare Advantage (HMO) plan with a Medicare contract. Enrollment in Farm Bureau Health Plans depends on contract renewal.