

**Use this form only if the member ID card says "Independent Health Self-Funded Services".**

Member Name: \_\_\_\_\_ Member ID# : \_\_\_\_\_

Name of Person Completing Form (if other than member): \_\_\_\_\_

Check all that apply to person completing form:     Member     Authorized Representative\*

Contact Information of Person Completing Form:

Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

**For Authorized Representative\***

\*Member Signature is Required: \_\_\_\_\_

*\*A valid HIPAA authorization form is required for the Plan to disclose protected health information to an authorized representative. If Independent Health Corporation does not have a valid HIPAA authorization on file for the authorized representative, a HIPAA authorization form will be mailed to the address above. An appeal submitted by an authorized representative cannot be processed without a valid HIPAA authorization.*

**Briefly describe why you disagree with this decision:**

*You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim. Standard appeal decisions are made within 15 days.*

**Certification:** *I hereby authorize Independent Health Self-Funded to release to the Peer Reviewer documents or information regarding the requested service(s). I acknowledge that Independent Health Self-Funded Services associates will access and review information to process this appeal.*

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return this form and denial notice to:** Independent Health Self-Funded Services, PO Box 1543, Buffalo, NY 14231  
*Keep copies of this form, your denial notice, and all documents and correspondence related to the service request.*

**Urgent appeals are available only for services that have not yet been provided.**

*For URGENT appeals, the **treating physician must complete** the information below. Only in urgent situations may the provider act as the Authorized Representative without requiring the member's signature.*

- My patient's health would be in serious jeopardy if required to wait for a standard appeal decision.
- My patient would experience pain that cannot be adequately controlled if required to wait for a standard appeal decision.

**Certification:** *I hereby certify that the above, in my professional opinion, presents an urgent situation requiring that my patient's appeal (member) be expedited.*

Name of Treating Physician (please print): \_\_\_\_\_

\_\_\_\_\_  
*Treating Physician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Phone*