

**COMMUNITY HEALTHFIRST™
APPEAL FORM**

Please select your plan:

- Medicare Advantage
- Medicare Advantage with Pharmacy (Part D)
- Medicare Advantage Special Needs Plan

Submit completed form to:
Community Health Plan
Attn: Medicare Appeal Coordinator
720 Olive Way, Suite 300
Seattle, WA 98101

Name	Telephone Number
ID Number	Provider Name
Date of Birth	Date(s) of Service
Address	

Please contact us if you need additional assistance in completing this form or if you have any questions at Community HealthFirst Customer Service Department, 7 days a week, from 8:00 a.m. to 8:00 p.m., at 1-800-942-0247 or TTY/TDD 1-866-816-2479.

Please explain your reason for filing this appeal: (attach additional sheets if necessary)

I hereby authorize my plan to obtain any medical records needed to review my appeal request. If applicable, this includes the release of information about alcohol or drug abuse, mental health, AIDS or HIV virus. This authorization begins on the date shown below and remains in effect as long as my request is being reviewed.

▶

Signature of Member or Authorized Representative*

Today's Date

* Please attach documentation demonstrating your authority to act on behalf of another. This may include a Power of Attorney or Appointment of Representative form (Form CMS-1696)