

Kentucky Medicaid MCO Member Appeal Request

Check the box of the plan in which the member is enrolled	MCO	Phone	Fax
	<input type="checkbox"/> Anthem BCBS Medicaid	1-855-661-2027 Ext. 26740	1-855-443-7820
	<input type="checkbox"/> Coventry Cares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	<input type="checkbox"/> Humana – CareSource	1-877-892-7487	1-855-262-9794
	<input type="checkbox"/> Passport Health Plan	1-800-578-0636	502-585-8461
	<input type="checkbox"/> WellCare of Kentucky	1-877-389-9457	1-866-201-1657

Please complete all appropriate fields
 If you need assistance with this form, call your MCO at the number listed above
 All Appeals must be filed within 30 days from the date of MCO action

Date _____

Person filing request _____ Email _____ Phone _____

I am a Medicaid member I am filing request on behalf of a Medicaid member

If filing on behalf of member, state relationship to member _____

Who is the Appeal for?

Member’s name _____

Member’s Social Security Number _____ Member’s DOB _____

Member’s address _____ County _____

Why are you requesting an appeal?

Procedure or Service you are requesting _____

Doctor or Provider of service _____ Phone _____

Doctor or Provider address _____

Reason for procedure/service _____

Please give as much detail as possible about this request:

Attach a copy of the denial letter along with any other correspondence concerning this request.

By signing this document, I authorize the person submitting this form to do so on my behalf

Signature of Member _____ Date _____

Signature of person filing request _____ Date _____

Members have the right to request a continuation of benefits while the Appeal is being processed