## Molina Healthcare of New York, Inc.

## **APPEAL REQUEST FORM**

FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

Mail To:				Fax to	315-234-	-9812	
Molina Healthc	are of New Y	ork, Inc.					
5232 Witz Drive				Today's date:			
North Syracuse	e, NY 13212						
DEADLINE:							
• If you want to ask within 10 takes effect, services you	calendar day whichever is	ys of the date later. (If you lo	of this notice ose your appe	e, or by the c	date the dec	cision	
• The last day t	o ask for a P	Plan Appeal to	keep your se	ervices the s	ame is [	].	
<ul> <li>You have a to Plan Appeal. I If you want a</li> </ul>	The last day	to ask for a P	an Appeal fo	r this decision		a <b>].</b>	
Enrollee Informatio	n:						
Name:	[	][	]				
Enrollee ID:	[	]					
Address:	[			][	,	]	
Home Phone:	[	]	Ce	II Phone: [		]	
Plan Reference	Number: [		]				
Service being re	educed, susp	ended or stop	oped: [		]		
I think the plan's de	cision is wroı	na because:					
		9					
				-			



	I do <u>NOT</u> want my decided.	services to stay the	same while my	Plan Appeal is being				
	☐ I request a Fast Track Appeal because a delay could harm my health.							
	☐ I enclosed additional documents for review during the appeal.							
	☐ I would like to give information in person.							
	I want someone to	ask for a Plan Appe	eal for me:					
	YES □  ° Do you want tl	this decision? You o	you for all steps	e? s of the appeal or fair f change your mind.				
Re	equester (person as	king for me):						
No	ame:		E- mo	ail:				
Ad	ddress:							
Ci	ity:	State: _		_Zip Code:				
Ph	none #:( )		Fax #: ( )					
Enrollee Si	gnature:		Date:					

Check all that apply:

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

