NHP Member Services
4944 Parkway Plaza Blvd, Suite 110
Charlotte, NC 28217

neighborhood HEALTH PROVIDERS ®

MEMBER APPEAL FORM

Member Information:

Name of Member involved in Appeal: ____________________ CIN #: ____________

Head of Household/Guardian: ____________________ File #: ____________

Address: ____________________ Telephone #: ____________

Explanation of Incident/Appeal:

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Reason(s) for Appeal:

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How would you like your appeal resolved/determined:

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Signature of Appellant or Designee: ____________________ Date: ____________

Please return this form to:

Neighborhood Health Providers
4944 Parkway Plaza Blvd, Suite 110
Charlotte, NC 28217
Attn: Appeals Unit or fax to 800-338-4195

You have no less than sixty (60) business days from the date you received the determination letter to file an appeal. For assistance in completing this form, please call our Member Services Department at 1-800-826-6240.

For Official Use Only — Please do not write below this line

Receipt of the Appeal (Date): ____________ Received by: ____________

Clinical Appeal: No Yes If yes, refer to: ____________ Date referred: ____________

Reviewed and approved by (Signature): ____________________ Date: ____________

Revised-03/31/2011