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Magellan HEALTH

Connect Nevada: Strengthening Youth, Empowering Families
Appeal Request Form

Today's Date:	
An appeal is when you ask someone to take another look at a decision they made about your child/youth's services, like if they said no to something or reduced it. If you disagree with what Magellan of Nevada decided about your child/youth's services, use this appeal form within 60 days of getting the first letter saying no.	
Authorization Number:	
Appeal Urgency: ☐ Standard Appeal Type: ☐ Program Eligibility ☐ Medical Necessity ☐ 14-Day Appeal Extension	
Date(s) of Services you are appealing (Start Date):	(End Date):
Provider Name:	Service Location:
Child/Youth's Information	
Child/Youth's Name (First, MI, Last):	
Street Address:	
City: State:	Zip Code:
Phone Number (Including Area Code):	Email:
Parent/Guardian (Name):	Phone Number:
(1) Tell us why you do not agree with our denial decision and (2) why you are filing the appeal To make your appeal stronger, include proof like the denial letter, medical records, notes from the doctor, test results, and any other documents that can help. Send these documents with the appeal form.	
Consent for My Provider to File an Appeal on my Behalf (Complete the section below and fill out the *Child/Youth Freedom of Choice Consent Form* and send back to us)	
The Child/Youth/Parent/Legal Guardian gives ☐ written ☐ verbal consent for _____ to file this appeal on _____.	
Authorized Representative Information You can ask someone to assist you with your appeal, like your healthcare provider. If you decide to do this, please let us know below and fill out the *Authorized for Use and Disclosure Form*, then send it back to us. This way, we can share the same appeal information with that person as we do with you, unless you ask us to stop.	
Authorized Representative Name (First, MI, Last):	
Street Address:	
City: State:	Zip Code:
Representative Phone Number:	Email:
Relationship to Member:	
You, the Child/Youth's Parent/Legal Guardian/Authorized Representative/Provider, need to sign this form	
Signed:	Date:

Mail, Email, or Fax this Appeal Request Form, Appeal Supporting Documents, Member Consent Form, and/or Authorized Use and Disclosure Form to:	**Please call our Customer Experience Associates (8:00 a.m.– 5:00 p.m. PST) if you have questions or need help with completing this Appeal Request Form.**
Attn: Magellan of Nevada Appeals & Grievances Department P.O. Box 2188 Maryland Heights, Missouri 63043 Email: NevadaAppealsGrievances@Magellanhealth.com Fax: 1-888-656-9795	Telephone: 1-833-396-4310 TTY: 7-1-1 MagellanofNevada.com