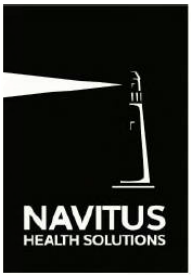

MEMORIAL HERMANN Health Plan

Memorial Hermann Health Plan, Inc.
Memorial Hermann Health Solutions, Inc.
Memorial Hermann Health Insurance Company
Memorial Hermann Commercial Health Plan, Inc.

Appeal Form

APPEAL RESPONSE
☐ Check box if this is an URGENT request

Step 1: CLEARLY PRINT AND COMPLETE – ALL FIELDS REQUIRED FOR APPEAL PROCESSING	
Date:	Prescriber First & Last Name:
Member First & Last Name:	Prescriber NPI:
Member Date of Birth:	Prescriber Specialty:
Member Phone Number:	Prescriber Phone Number:
Member Insurance ID Number:	Prescriber Fax:

Step 2: COMPLETE REQUEST INFORMATION	
Drug/Dose:	Diagnosis:
☐ Continuation Therapy ☐ Initial Therapy	
Drugs/ Therapies previously tried/failed for this diagnosis:	

Step 3: APPEAL

Use the space provided below to appeal the initial denial of this request

- Refer to the initial request denial letter and address each denial reason within this appeal.
- If denied due to formulary alternatives, address each drug listed within the initial request denial.
- Use clinical reason(s)/rationale to explain your disagreement with the initial denial of this request.
- Provide chart notes, medical studies/journals and/or any other information relevant to this request.

Step 4: SIGN AND FAX TO: APPEAL COORDINATOR AT: 855-673-6507

Prescriber Signature: _____ Date: _____

Appeal Department business hours are M-F 8am-6pm CST, decision turnaround times are adjusted accordingly.

For questions, please call Navitus Customer Care at 1-844-268-9789.