Redetermination/Appeal Request Form

Member's Name:_____ Member ID Number:_____

Description of issue or service in question:_____

Date the service was received:_____

I do not agree with the initial determination because:_____

_____

Date of the initial determination notice:_____

If you received your initial determination notice more than 60 days ago, what is your reason for not making this request sooner? _____

_____

Additional Information that CommunityCare should consider: _____

_____

_____

_____

_____

Member's Signature: _____ Date Signed: _____

If this form is completed by someone other than the member please note the following:
You may appoint any individual (such as, but not limited to, a relative, friend, advocate, attorney or physician) to act as your representative. Also, a representative (surrogate) may be authorized by the court or act in accordance with State law to act on your behalf. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney, a health care proxy, or a person designated under a health care consent statute. For more information on how to name your authorized representative or to request an Appointment of Representative form (AOR) please call 1-800-642-8065 Monday through Friday 8 a.m. to 5 p.m. *(Hearing impaired members may call TTY/TDD via Relay Oklahoma at 1-800-722-0353).* AOR forms are also available online at www.ccok.com.

☐ I have evidence to submit (please attach to this form)
☐ I do not have evidence to submit