

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Office of Health Care Ombudsman and Bill of Rights



APPEAL NO: \_\_\_\_\_

APPEAL FORM

I, \_\_\_\_\_ (Member/Member Representative), hereby request  
(Name of Member/Member Representative)  
that the Director/Administrator of the Office of Health Care Ombudsman and Bill of  
Rights review the final decision rendered by \_\_\_\_\_.  
(Name of Health Plan)

1. DESCRIPTION OF REVIEW REQUESTED (Check one of the following)

1. Medical Necessity (Urgent or Emergency Care) \_\_\_\_\_
2. Medical Necessity (Concurrent or Prospective Appeal) \_\_\_\_\_
3. Benefit Coverage Review \_\_\_\_\_
4. Other \_\_\_\_\_

2. PATIENT INFORMATION

Patient's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_  
Email: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Language Spoken: \_\_\_\_\_  
# In Household: \_\_\_\_\_ Veteran Status: \_\_\_\_\_  
Employment Status: \_\_\_\_\_ Monthly Income: \_\_\_\_\_

3. MEDICAL INFORMATION

Diagnosis

(es): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Procedure(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Physician: \_\_\_\_\_  
Address: City, State, Zip : \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax: \_\_\_\_\_

Treating Facility: \_\_\_\_\_  
Address: City, State, Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

4. HEALTH PLAN INFORMATION

Name of Health Plan: \_\_\_\_\_  
Address: City, State, Zip: \_\_\_\_\_  
Member Identification Number: \_\_\_\_\_

Date of Final Decision: \_\_\_\_\_ **(ATTACH COPY)**

