Request for Reconsideration/Appeal of Medical Coverage Denial

Because we Leon Health, Inc. denied your request for coverage of (or payment for) a medical service, item, or Part B Drug you have the right to ask us for a reconsideration (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medical Coverage to ask us for a reconsideration. This form may be sent to us by mail or fax:

Address:
Leon Health, Inc.
PO BOX 668230
Miami, FL 33166

Fax Number:
(305) 718-2862

You may also ask us for an appeal through our website at www.leonhealth.com. Expedited appeal requests can be made by phone at 1-844-969-5366/1-844-9/MY-LEON. Our hours of operation are from 8:00 a.m. to 8:00 p.m., seven days a week from October 1st through March 31st and Monday through Friday during the rest of the year. Outside of normal business hours and during federal holidays, you may leave a message and we will return your call within one (1) business day.

Who May Make a Request: Your provider/prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____ Enrollee's Member ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's provider/prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696, a written equivalent, or other legal representative documentation) if it was not submitted at the organization determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

Medical Service/Item/Part B Drug you are requesting:

Name of Service/Item/ Part B drug: _____

Provider/Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions

If you or your provider believe that waiting 30 days for a medical service/item or 7 days for a Part B Drug standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 30 days for a medical service/item or 7 days for a Part B Drug could seriously harm your health, we will automatically give you a decision within 72 hours or 17 days if an extension is required for medical/services of items. If you do not obtain your provider's/prescriber's support for an expedited appeal, we will decide if your case requires a fast decision.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS (if you have a supporting statement from your provider/prescriber, attach it to this request).**

Please explain your reasons for appealing.

Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your provider/prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medical Coverage and have your provider/prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents.

_____
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If you're asking for an appeal and missed the 60-day deadline (from the date of your Notice of Denial of Medical Coverage), please include your reason for submitting late.

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Signature of person requesting the appeal (the enrollee or the representative):

_____ **Date:** _____