Sonder Health
A Medicare Advantage Company

MEDICARE MEMBER APPEAL REQUEST FORM

Members who have received a denial notice (i.e. Integrated Denial Notice) should follow the directions on that letter when submitting an appeal or information in the Member Evidence of Coverage (EOC). Failure to submit timely and to the correct location can delay your appeal from being processed.

This form is to be used on all Medicare Member liability appeals only. You do not have to use this form. We provide this form to help you submit the information we need to properly review your appeal.

Mail: Sonder Health Plans ATTN: Member Appeals 6190 Powers Ferry Road, Suite 320 Atlanta, GA 30339
Or Fax: (941) 866-2319 Or Email: Appeal@SonderHealthPlans.com

Appeal Information – You must select one

☐ Pre-Service (did not receive service/drug) Authorization #: _____

☐ Check here if you believe applying the standard processing timeframes could seriously jeopardize the Member's health, life, or ability to regain maximum function (not applicable for Payment/Claims Appeals).

☐ Payment/Claim Denial Claim #: _____ Date of Service: _____

Requestor Information – you must be or are representing the Member with this Appeal

☐ I am the Member (skip to next section) ☐ I am a Representative of the Member (complete section)

Which authorized submitter are you: Relationship: _____

☐ Anyone can be appointed by the Member to represent them in filing an appeal. Legal documentation or the CMS approved Appointment of Representative (AOR) Form is required and can be located here: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

☐ For Providers requesting a Pre-Service appeal: If the Appeal is not requested by the Member's treating physician or staff of the physician's office acting on the treating physician's behalf (e.g., request is on the physician's office practice letterhead or otherwise indicates staff is working under the direction of the treating physician), an Appointment of Representative (AOR) Form may be required (see above).

☐ For Non-Participating Providers requesting a claims/payment denial: You may appeal on your own behalf, but only if the WOL Form is included: https://sonderhealthplans.com/provider-documents-forms/

Submitter Full Name: _____

Direct Phone: _____ Fax: _____

Notice to Participating Providers: Claim and payment disputes must be handled through the appropriate Participating Provider Dispute or Reconsideration Process. This form is reserved for Member Appeals ONLY.

Member Information

Member Name: _____

Date of Birth: _____ Sonder Plan ID: _____

Address: _____ Phone: _____

Reason for Appeal (attach copy of denial notice & any other documentation we should consider):