Pharmacy
Member Appeal Form

Instructions

This form is for pharmacy appeals only. Please complete this form in its entirety to ensure accurate and timely processing of your appeal; incomplete information may delay the review and resolution of your appeal. Please be sure to include all relevant information with this form. If you are submitting this appeal on behalf of another person who is age 18 or over, a signed Designation of Personal Representative for Claim Appeal may be required to process your appeal.

Member/Patient Information

Last Name	*First Name*	*Member ID#*

Mailing Address	*City*	*ST*	*ZIP Code*

Date of Birth	*Email Address*	*Primary Phone#*

Submitter Information

Name of Person Submitting Appeal	*Relationship to Member (Attach Designation of Personal Representative Form)*

Mailing Address	*City*	*ST*	*ZIP Code*

Email Address	*Primary Phone#*

Claim#(s) (if applicable)/Rx Auth denial #	*Date(s) of Service/Date(s) of Fill:*

Please explain your reasons for submitting this appeal *(attach additional pages if necessary)*:

Submit completed form and supporting documentation to:

MVP Health Care
625 State Street
Schenectady, NY 12305
Attn: Member Appeals

Fax: 518-386-7600

Have Questions?
Give us a call at 844-260-9900