APPLICATION FORM

Request for Assistance to Appeal Denial of Coverage for All or Part of Medically Necessary Substance Abuse Treatment

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APPLICANT INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: ____ ZIP Code: _____

Phone Number: _____ Email: _____

INSURANCE INFORMATION

Member's Name: _____ Relationship to Applicant: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company Contact Information

Company Name: _____

Mailing Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Name of Insurance Company Representative (if known): _____

Is the member's insurance plan provided by an employer? Yes: ____ No: ____

Employer's Name: _____

Employer's Phone Number: _____

Is the employer's insurance plan self-funded?
(if uncertain, please check with employer) Yes: ____ No: ____

Is the applicant's insurance plan provided through Medicaid? Yes: ____ No: ____

If yes, please provide the Medicaid ID number and complete the following records release:

Medicaid ID Number: _____

I, _____, hereby authorize the Delaware Department of Justice to release my file to the Delaware Department of Health and Social Services, if I request a Medicaid Fair Hearing. I understand that DHSS will use this information to make a Fair Hearing determination and that the information will be held confidential.

_____
signature of applicant (or legal representative—note relationship)

HEALTH CARE PROVIDER INFORMATION

Primary Care Provider (PCP) Information

Name: _____

Mailing Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Treating Health Care Provider Information

Name: _____

Clinical Specialty: _____

Mailing Address: _____

City, State, ZIP Code: _____

Phone Number: _____

INFORMATION ABOUT INSURANCE COVERAGE DENIAL

In your words, describe the health insurance company's decision regarding the full or partial adverse determination regarding coverage for your substance abuse treatment. Include any information you have about the treatment sought (such as services, supplies, or medication), including dates of any service or treatment you have received, and the names of health care providers involved.

Please attach the following:

- Additional pages, if necessary
- Pertinent medical records in your possession
- If possible, a statement from your treating health care provider indicating why the treatment sought is medically necessary.

Information About Insurance Coverage Denial (*continued*)

REQUEST FOR ASSISTANCE AND AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby request that the Delaware Department of Justice provide assistance to me in connection with my appeal from my health insurance company's adverse determination regarding coverage for all or part of my substance abuse treatment, and authorize the Delaware Department of Justice to take all steps necessary to determine whether I am eligible for assistance and, if so, whether assistance can be provided and on what terms. I understand that such steps may involve referrals to or consultations with individuals, agencies, or organizations outside the Delaware Department of Justice, including licensed clinical social workers and potential legal counsel, and authorize the Department of Justice to provide the confidential information contained in this request for assistance to such individuals, agencies, or organizations.

If the Delaware Department of Justice concludes that it is able to provide assistance, I authorize the Delaware Department of Justice to pursue my appeal on my behalf. I recognize and understand that pursuit of such an appeal may involve referral to free private legal counsel, and if that occurs, and I choose to use the services of such counsel, I understand that I may need to execute an engagement letter or provide additional authorizations and releases in order for that counsel to accept the engagement.

_____ _____

Signature Date