Appeals Form

Thank you for contacting Magellan Complete Care. All appeals *must be submitted in writing* to:

Magellan Complete Care
Attn: Grievance and Appeals Department
P.O. Box 691029
Orlando, FL 32869

Magellan Complete Care (for clinical appeals only)
Attn: Complaint Coordinator
P.O. Box 2064
Maryland Heights, MO 63043

Member name: | Member ID:

Address:

Cell phone number: | Home telephone number:

The following items are included with my appeal:

- ○ Copy of the original claim
- ○ Medical Records enclosed
- ○ Proof of Eligibility
- ○ Prior authorization from Magellan Complete Care
- ○ Other documents

What is the best time to speak with you? ○ 8:30 am – 12:30 pm ○ 1:00 pm – 5:00 pm

I have received a copy of my Appeal Rights in my Member Handbook. If I need assistance with understanding my Rights, Magellan Complete Care will assist in explaining this to me.

____ ________________

Signature of Member/Representative/Legal Guardian *Date*

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Print Name of Member/Representative/Legal Guardian

Contact telephone number: | Relationship if not member:

Type of Appeal:
○ Regular appeal
○ Expedited appeal *(must demonstrate proof of medical emergency)*

Need assistance? Please call 1-800-327-8613 (TTY 711)