**Molina Healthcare de Puerto Rico**
**Medical Appeals Form**

**If you wish to appeal our decision, you must complete this form and return it within 60 calendar days of the Notice of Adverse Benefit Determination. You can also call within 60 calendar days of the date the Notice of Adverse Benefit Determination. If you call first, send us this form within 10 calendar days of calling us.**

**If your health care provider understands that your life or health is exposed to some imminent danger due to the decision referred to in the Notice of Adverse Benefit Determination, the provider may request an expedited appeal by calling us or sending us this form.**

If you need help completing this form, please contact us at (877) 335-3305, TTY users must call 711, during service hour Monday to Friday from 7:00 am to 7:00pm.

**Who presents this appeal?**
☐ **Member** ______________________ Member ID Number: ____________________
☐ **Provider:** ______________________ NPI: ____________________
☐ **Other:** ______________________

**Appeal Date:** ______________ **Notice of Adverse Determination Date:** ______________

Member's Information

Last Names: ______________________ Name: ________________ Initial: ______
Current Address: ________________________________________ Apt. ______
City: ______________________ PR __________ Zip: __________
Telephone Number: ______________________
Service Denied: ______________________
Provider Name: ________________________________________

Explain why you are appealing and include any other comment you want:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________