

APPEAL REQUEST FORM

- Fill out and sign this form
- Send completed and signed form with any supporting documentation to:
Samaritan Health Plans
P.O. Box 1310
Corvallis, Oregon 97339

MEMBER INFORMATION:

Name (please print):

Member ID#:

APPEAL INFORMATION:

I would like to appeal:

The reasons I think the decision should be changed are:

YOUR SIGNATURE:

You or your authorized representative must sign and date this request. If the appeal is on behalf of a minor, the minor's legal guardian must sign. If this form is not signed, Samaritan Health Plans will not process your appeal.

Signature:

Date:

Relationship to Member: