Member Appeal Form

Complete this form if you are appealing the outcome of a processed medical need. Please include any supporting documents, notes, statements, and medical records, if necessary.

Please Note:
Your appeal must be received within 180 days of the initial determination date (Print Date on your Sharing Summary).

Notify your provider's billing office that you are appealing a denial of sharing so they may note your account accordingly.

Please allow 45-60 days for appeals to be reviewed.

Type of Appeal: Member ______ Provider _______

Send appeal to:

Alliance for Shared Health
Attn: Appeals
3155 Sutton Blvd. Suite 201
St. Louis, MO 63143
Fax: 314-492-8686 Attn: Appeals

Scan and Email:
Memberservices@sharedhealthalliance.com
Attn:Appeals

Member Name:		Date of Birth:
Address:		
City:	State:	ZIP Code:
Contact Number:	Contact Email:	
Member's Active Date:	Member Number:	
Is the appeal in regards to a need in your name or a dependent? SELF DEPENDENT (circle one)	Dependents Name (If applicable):	

Appeal Information

Date(s) of Service:	Needs # (Listed on your Sharing Summary Statement)	
Doctor/Provider:	Medical Service/Care Received:	
Address:		
City:	State:	ZIP Code:

Date(s) of Service:	Needs #	
Doctor/Provider:	Medical Service/Care Received:	
Address:		
City:	State:	ZIP Code:

Reason for the Appeal

Member Signature:	Today's Date:

For Internal Use

Appeal Approved:	Today's Date:
Processing Method:	