MEDICARE ADVANTAGE
APPEAL FORM

Submit completed form to:

Medicare Advantage
Appeals and Grievance B32AG
PO Box 1827
Medford OR 97501
Email: MedicareAppeals@regence.com
Fax: 1 (888) 309-8784

Preferred correspondence method:

☐ Mail
☐ Email _____

Name	Telephone Number
ID Number	Provider Name
Date of Birth	Date of Service
Address	

Please feel free to contact us if you need additional assistance in completing this form. Our office hours are 8:00 a.m. to 5:00 p.m. PT Monday through Friday. Our toll-free number is 1 (866) 749-0355 (TTY: 711).

Please explain your reason for filing this appeal: (attach additional sheets if necessary)

I hereby authorize my plan to obtain any medical records needed to review my appeal status. If applicable, this includes the release of information about alcohol or drug abuse, mental health, AIDS or HIV virus. This authorization begins on the date shown below and remains in effect so long as my request is being reviewed.

Signature of Member or Authorized Representative* **Today's Date**

*Please attach documentation demonstrating your authority to act on behalf of another. This may include a Power of Attorney or Appointment of Representative form (Form CMS-1696).