



## Member Appeal Form

Note: If you believe this case involves a medical emergency, call Avera Health Plans immediately at 605-322-4545 or toll-free at 888-322-2115

### Subscriber Information

_____	_____	_____	_____
Last Name	Middle Initial	First Name	Member Plan ID Number
_____		_____	_____
Street Address		City	State ZIP
_____-_____-_____	_____-_____-_____		
Home Phone Number	Cell Phone Number		

### Member Information

(If patient information is different than subscriber)

_____	_____	_____	_____
Last Name	Middle Initial	First Name	Member Plan ID Number
_____		_____	_____
Street Address		City	State ZIP
_____-_____-_____	_____-_____-_____		
Home Phone Number	Cell Phone Number		

### Provider Information

(If your provider is appealing on your behalf please complete this section)

Note: Providers must have a signature from the member to authorize him or her to appeal on the member's behalf.

_____	_____-_____-_____
Provider/Medical Group Name	Phone Number
_____	_____
Street Address	City State ZIP

Is your provider authorized to appeal on your behalf?  Yes  No

If yes, please have the member sign below:

\_\_\_\_\_  
Member Signature

## Appeal Information

Please briefly outline the specific details of your appeal and when the event(s) occurred. Include a statement regarding the outcome desired and what you believe we can do to resolve your concern. If you have copies of invoices, checks, documents or other correspondence related to the problem that may help in the investigation and resolution, please include them with this form. If you need more pages to explain the issue, please attach them to this form.

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You may have the right to file an appeal on a claim decision by sending a written request and pertinent information to support your appeal within 180 days from the date of the denial or claims payment. You must submit copies of documents or other correspondence related to this appeal to help in the investigation and resolution. Refer to your current Certificate of Coverage or Summary Plan Document (SPD) for information on the appeal process. If we continue to deny payment, coverage or service requested or you do not receive a timely response to your appeal, your plan may have additional appeal options available.

You have the right, at any time throughout this process; to submit an appeal to the appropriate regulatory agency in the state the subscriber is employed. For members who work and receive their health insurance from employers located in South Dakota, call 605-773-3563; for Iowa, call 515-281-6348 and for Nebraska, call 402-471-2201.

Your plan may be governed by the Employee Retirement Income Security Act (ERISA) and you may have the right to bring a civil action under section 502(a) of ERISA after you have exhausted the mandatory appeals levels that are described in your Certificate of Coverage or Summary Plan Document.

If you have any questions regarding your coverage or appeal rights with Avera Health Plans, please call our Service Center at 605-322-4545 or toll free at 888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday.

I certify that this information is true and correct

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Member or Provider Signature

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Date

Email the completed Member Appeal Form and your supporting documents to [ComplaintAppeals@AveraHealthPlans.com](mailto:ComplaintAppeals@AveraHealthPlans.com) or mail to the following address:

Attention: Complaint and Appeals Coordinator  
Avera Health Plans  
3816 S. Elmwood Ave., Suite 100  
Sioux Falls, SD 57105-6538

## Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,  
200 Independence Avenue SW Room 509F, HHH Building,  
Washington, D.C. 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### Complaint and Appeals Coordinator

Avera Health Plans  
3816 S. Elmwood, Suite 100,  
Sioux Falls, SD 57105-6538

Fax 1-800-269-8561

Email [ComplaintAppeals@AveraHealthPlans.com](mailto:ComplaintAppeals@AveraHealthPlans.com)



## Getting Help in other Languages

Language assistance services are available free of charge. Our Service Center is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- US CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113)。
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-322-2115-1 (رقم هاتف الصم والبكم: 1-800-877-1113-1).
- ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-322-2115 (TTY: 1-800-877-1113).
- ທີ່ຮຽນສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາ ທີ່ບໍ່ເປັນພາສາອັງກິດ ຫຼື ພາສາສະໂຫຼວງ ທ່ານສາມາດຮັບການຊ່ວຍເຫຼືອດ້ານພາສາ ທີ່ບໍ່ມີຄ່າ. ໂທ: 1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (TTY: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ພື້ນຖານ: ຖ້າທ່ານເວົ້າພາສາ ທີ່ບໍ່ເປັນພາສາອັງກິດ ຫຼື ພາສາສະໂຫຼວງ ທ່ານສາມາດຮັບການຊ່ວຍເຫຼືອດ້ານພາສາ ທີ່ບໍ່ມີຄ່າ. ໂທ: 1-888-322-2115 (TTY: 1-800-877-1113).
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY- Telefon za osobe sa oštećenim govornom ili sluhom: 1-800-877-1113)
- ປຼຳໜ້າ: ເມື່ອທ່ານເວົ້າພາສາ ທີ່ບໍ່ເປັນພາສາອັງກິດ ຫຼື ພາສາສະໂຫຼວງ ທ່ານສາມາດຮັບການຊ່ວຍເຫຼືອດ້ານພາສາ ທີ່ບໍ່ມີຄ່າ. ໂທ: 1-888-322-2115 (TTY: 1-800-877-1113)