UNIVERSITY of MARYLAND
HEALTH ADVANTAGE

Request for a Reconsideration (Appeal) Form
For Inpatient and/or Outpatient Services

A. Member Information		
Member ID Number	Telephone No: ( ) -	
Last Name	First	MI
Street Address:		
City:	State/ Zip Code:	Date of Birth:

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Last Name	First	MI
Street Address:		
City:	State/ Zip Code:	Relationship to Member:

Date the Item or Service was Provided:

Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 60 days ago, include your reason for the late filing.)

I do not agree with the determination decision on my claim because:

Additional Information University of Maryland Health Advantage should consider:

☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it.

☐ I do not have evidence to submit.

Signature _____ Date _____

Authorized Representatives must complete an Authorized Representative form and submit it with this appeal form or have one on record with the health plan.

Mail or Fax this Request to:

University of Maryland Health Advantage
Attention: Appeals & Grievance
Department 1966 Greenspring Drive, Suite
100 Timonium, Maryland 21093
Fax: 1-844-329-0831

University of Maryland Health Advantage is a HMO-SNP plan with a Medicare contract and a State of Maryland Department of Health and Mental Hygiene (Medicaid) program contract. Enrollment in University of Maryland Health Advantage depends upon contract renewal.

University of Maryland Health Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-262-1122 (TTY: 711).

.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 1-844-262-1122 (TTY: 711).