



NJ FamilyCare (Medicaid) Appeal Request Form

This form is to help you submit your appeal. When complete, you can either fax or mail this form to us, along with any medical records you want us to see. The address and fax number are on the top of the form.

You can also appeal by phone instead by calling **1-888-453-2534** (TTY: **711**).



Please follow the instructions below to complete the form.

- ✓ **Section A:** Please complete all information, including a current phone number.
- ✓ **Section B:** Please give the name of the person submitting the appeal. If you are the member, write your own name and contact information in this section and check the box next to “Member.” If you are a parent or guardian submitting on behalf of the member, write your name and check the box next to “Parent/Guardian.”

You can also have someone make an appeal for you. This is called *appointment of representation*. If you would like someone to appeal for you, please write their information in Section B and complete Section G as well.
- ✓ **Section C:** Tell us if you need an expedited appeal. You should select “Expedited Appeal” (which will be decided in 72 hours or less) if you or your provider believe the standard 30-day timeframe for deciding an appeal is too long and could harm your health. Otherwise, you should select “Standard Appeal.” Please note that if you have already had the service, you are not able to ask for an expedited appeal (72-hour decision).
- ✓ **Section D:** Please tell us your language preference for any letters we send or any phone calls we make to you during this process.
- ✓ **Section E:** Tell us what kind of adverse decision/denial (such as a denial of a prior authorization, or a reduction or termination of an ongoing service) that you received. Please provide a reference/authorization number or a claim number or date of service, if available.
- ✓ **Section F:** Please tell us why you disagree with our decision.
- ✓ **Section G:** This section MUST be completed when anyone other than the member and/or a parent or guardian is making the appeal.



Questions?

Please call Member Services at **1-888-453-2534** (TTY: **711**). You can reach us Monday through Friday, from 8 a.m. to 6 p.m. You can also visit us online at **fideliscarenj.com**.

NJ FamilyCare (Medicaid) Appeal Request Form

Please complete the form below and return it by one of the following methods.



FAX this form to: **1-866-201-0657** |



MAIL this form to: **Fidelis Care of NJ**

Attn: Appeals Department

P.O. Box 31368

Tampa, FL 33631-3370



You can also call us at **1-888-453-2534** (TTY: **711**) to appeal.

A. MEMBER INFORMATION	B. PERSON SUBMITTING THIS FORM <i>(Select relation to member.)</i>
Member Name:	Name:
Member ID:	<input type="checkbox"/> Member <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Provider <input type="checkbox"/> Other _____
Member Date of Birth: / /	Phone Number:
Member Phone Number:	Fax / Mailing Address:
<i>If anyone other than the member or their parent / guardian is completing this form, you must complete Section G. If a parent or guardian is completing this form, Section G is not required.</i>	
C. TYPE OF APPEAL <i>(Please note: If services have already been provided to you, you cannot ask for an expedited appeal.)</i>	
<input type="checkbox"/> Expedited Appeal (72-hour decision) <input type="checkbox"/> Standard Appeal (30-day decision)	
D. LANGUAGE	
My preferred language is _____ . Please send all letters and other communications in that language.	
E. TYPE OF ADVERSE DECISION/DENIAL YOU ARE APPEALING <i>(Check the box for the type that applies to you and provide all information to the best of your ability.)</i>	
<input type="checkbox"/> PRIOR AUTHORIZATION DENIAL (Denial or partial denial of an initial request for a service)	Reference Number:
<input type="checkbox"/> REDUCTION OR TERMINATION (Reduction or termination of the hours/units of an ongoing service you have been receiving)	Reference Number:
<input type="checkbox"/> REIMBURSEMENT DENIAL (Denial to pay you back for a service you paid for in advance)	Payment Date or Date of Service:
F. APPEAL STATEMENT <i>(Please tell us why the service should be approved. Send any medical records you would like us to see. Use the back of this form if you need more space.)</i>	

G. APPOINTMENT OF REPRESENTATION

I, _____, the member or the member's parent / guardian, consent to
(Member OR parent / guardian's name)

_____, my _____, acting
(Name of person you are allowing to appeal) (Who is this person to you? Ex. doctor, friend)
on my behalf for this appeal request.

Member's Signature

Member's Name

Date

Appointment of Representative Signature

Appointment of Representative Name

Date

Discrimination Is Against the Law

Fidelis Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). **Fidelis Care** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Fidelis Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - 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
 - Information written in other languages.

If you need these services, contact Member Services at **1-888-453-2534** (TTY: **711**).

If you believe that **Fidelis Care** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

1557 Coordinator
PO Box 31384, Tampa, FL 33631
Phone: **1-855-577-8234** (TTY: **711**)
Fax: **1-866-388-1769**
Email: **SM_Section1557Coord@centene.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

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 by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **<https://www.hhs.gov/ocr/complaints/index.html>**

This notice is available at Fidelis Care website:

<https://www.fideliscarenj.com/notice-of-non-discrimination.html>

If English is not your first language, we can translate for you. Fidelis Care offers no cost language assistance, auxiliary aids and services, larger font materials, oral translation, and other alternative formats. For assistance call **1-888-453-2534** (TTY: **711**), Monday through Friday, from 8 a.m. to 6 p.m.

Si el español es su idioma principal, podemos traducir para usted. Fidelis Care ofrece asistencia lingüística gratuita, ayudas y servicios auxiliares, materiales con la letra más grande, traducción oral y otros formatos alternativos. Para obtener asistencia, llame al **1-888-453-2534** (TTY: **711**) de lunes a viernes, de 8 a.m. a 6 p.m.

如果中文是您的母語，我們可以為您翻譯。Fidelis Care 提供免費的語言協助、輔助工具和服務、大字體印刷資料、口譯和其他替代格式。如需協助，請撥打 **1-888-453-2534** (TTY **711**)，週一至週五上午 8 點至下午 6 點。

한국어가 모국어인 경우 당사가 번역해 드릴 수 있습니다. Fidelis Care는 언어 보조, 보조 지원 및 서비스, 큰 글씨 자료, 구두 번역 및 기타 대체 형식을 무료 제공합니다. 지원이 필요한 경우 **1-888-453-2534** (TTY **711**)번으로 월요일~금요일, 오전 8시~오후 6시까지 전화해 주십시오.

Se o português for a sua língua materna, podemos traduzir para si. A Fidelis Care oferece assistência, apoios auxiliares e serviços, materiais com tipos de letra de maior dimensão, tradução oral e outros formatos alternativos no seu idioma e sem custos. Para obter assistência, ligue para o número **1-888-453-2534** (TTY: **711**), de segunda-feira a sexta-feira, das 08:00 às 18:00.

જો ગુજરાતી તમારી પ્રથમ (માતૃ) ભાષા હોય, તો અમે તમારા માટે અનુવાદ કરી શકીએ છીએ. Fidelis Care કોઈ પણ ખર્ચ વિનાની ભાષા સંબંધી સહાયતા, સહાયક સહાય અને સેવાઓ, વધુ મોટા ફોન્ટની સામગ્રીઓ, મૌખિક અનુવાદ અને અન્ય વૈકલ્પિક ફોર્મેટ ઓફર કરે છે. સહાયતા માટે, સોમવારથી શુક્રવાર, સવારે 8 વાગ્યાથી સાંજે 6 વાગ્યા સુધીમાં, **1-888-453-2534** (TTY: **711**) પર કોલ કરો.

Jeśli język polski jest Twoim językiem ojczystym, możemy zapewnić Ci tłumaczenie. Firma Fidelis Care oferuje bezpłatne wsparcie językowe, dodatkowe pomoce i usługi, materiały z większą czcionką, tłumaczenia ustne oraz inne alternatywne formaty. Aby uzyskać pomoc, zadzwoń pod numer **1-888-453-2534** (TTY: **711**), telefon czynny od poniedziałku do piątku w godzinach od 8:00 do 18:00.

Se l'italiano è la tua prima lingua, possiamo occuparci della traduzione per te. Fidelis Care offre gratuitamente assistenza linguistica, supporti e servizi ausiliari, materiali con caratteri più grandi, traduzione orale e altri formati alternativi. Per assistenza chiama il numero **1-888-453-2534** (TTY: **711**), dal lunedì al venerdì, dalle 8:00 alle 18:00.

إذا كانت العربية لغتك الأولى، فيمكننا توفير خدمة الترجمة لك. تقدم Fidelis Care خدمات مساعدة لغوية ومساعدات وخدمات إضافية ومواد بخط أكبر وترجمة شفوية وغيرها من التنسيقات البديلة مجانًا. للحصول على المساعدة، اتصل على الرقم **1-888-453-2534** (TTY: **711**)، من الاثنين إلى الجمعة، من الساعة 8 صباحًا حتى الساعة 6 مساءً.

Kung Tagalog ang pangunahin ninyong wika, puwede kaming magsalin para sa inyo. Nag-aalok ang Fidelis Care ng libreng tulong sa wika, mga karagdagang tulong at serbisyo, mga materyal sa mas malalaking font, pasalitang pagsasalin, at iba pang alternatibong format. Para sa tulong, tumawag sa **1-888-453-2534** (TTY: **711**), Lunes hanggang Biyernes, mula 8 a.m. hanggang 6 p.m.

Если вашим родным языком является русский язык, мы можем выполнить для вас перевод. Fidelis Care предлагает бесплатные услуги языковой поддержки, вспомогательные средства и услуги, включая услуги устного перевода, а также материалы крупным шрифтом и в других альтернативных форматах. Для получения помощи позвоните по номеру **1-888-453-2534** (TTY: **711**) с понедельника по пятницу с 8 a.m. до 6 p.m.

Si Kreyòl Ayisyen se lang matènèl ou, nou kapab tradui pou ou. Fidelis Care ofri asistans lang gratis, èd ak sèvis oksilyè, dokiman ki nan gwo karaktè, tradiksyon oral, ak lòt fòm altènatif yo. Pou jwenn asistans rele **1-888-453-2534** (TTY: **711**), Lendi jiska Vandredi, soti 8 a.m. rive 6 p.m.

अगर हिंदी आपकी पहली भाषा है तो हम आपके लिए अनुवाद कर सकते हैं. Fidelis Care निःशुल्क भाषा सहायता, सहायक साधन और सेवाएं, बड़े फॉन्ट वाली सामग्री, मौखिक अनुवाद और अन्य वैकल्पिक फॉर्मेट प्रदान करता है. सहायता के लिए **1-888-453-2534** (TTY: **711**) पर सोमवार से शुक्रवार, सुबह 8 बजे से शाम 6 बजे तक कॉल करें.

Nếu tiếng Việt là ngôn ngữ mẹ đẻ của quý vị, chúng tôi có thể phiên dịch cho quý vị. Fidelis Care cung cấp miễn phí hỗ trợ ngôn ngữ, dịch vụ hỗ trợ và trợ giúp phụ trợ, tài liệu phong chữ lớn hơn, phiên dịch và các định dạng thay thế khác. Để được hỗ trợ, hãy gọi số **1-888-453-2534** (TTY: **711**), Thứ Hai đến Thứ Sáu từ 8 a.m. đến 6 p.m.

Si le français est votre langue principale, nous pouvons vous fournir une traduction. Fidelis Care propose une assistance linguistique gratuite, des aides et services auxiliaires, des polices de caractères plus grandes, une traduction orale et d'autres formats. Pour obtenir de l'aide, appelez le **1-888-453-2534** (TTY : **711**), du lundi au vendredi, de 8 h à 18 h.

اگر اردو آپ کی مادری زبان ہے، تو ہم آپ کے لیے ترجمہ کر سکتے ہیں۔ Fidelis Care مفت میں زبان کی معاونت، اضافی امداد اور خدمات، بڑے فونٹ کے مواد، زبانی ترجمہ، اور دیگر متبادل فارمیٹس فراہم کرتا ہے۔ مدد کے لیے **1-888-453-2534** (TTY: **711**) پر کال کریں، پیر تا جمعہ، صبح 8 بجے سے شام 6 بجے تک۔

