Partnership HealthPlan of California
Request for
Appeal/ Expedited Appeal of UM or Pharmacy Decision

Requesting Provider: _____
Please Print

Member Name: _____
Please Print

Member's Authorized Representative: _____
(if applicable) Please Print

ID Number _____

Service Denied _____

Date of Denial _____

TAR Number _____

Do you wish this request to be expedited? ☐ Yes ☐ No
Expedited appeals are performed only when a delay in decision making might seriously jeopardize the life or health of the member.

Please state the reason: _____

I am supplying additional clinical information and wish to appeal the original decision
Please sign and date and attach documentation to this form

_____

-----OR-----

I do not have additional clinical information. I am appealing the original decision

Please sign and Date:

_____

Please submit completed form to PHC UM Dept. Fax: (707) 863-4118 or Pharmacy Dept. Fax: (707) 863-4330