

**APPEAL REQUEST – INDEPENDENT CARE HEALTH PLAN**

Completing this form is voluntary. Personally identifiable information collected on this form is used to identify your case and process your request only.

Name – Member		Today's Date
Mailing Address		
City	State WI	Zip Code

Check this box if you would like to appeal Independent Care Health Plan's decision by requesting a meeting with the Independent Care Health Plan Grievance and Appeal Committee.

**Continuing your services during an appeal of a reduction, suspension, or termination of a service**

If you are getting benefits and you ask for an appeal before your benefits change, you can keep getting the same benefits until a decision on your appeal has been made. If you want to keep your benefits during your appeal, your request must be postmarked or faxed **on or before the effective date of the intended action**. If the Grievance and Appeal Committee decides that Independent Care Health Plan's decision was correct, you may need to repay the extra benefits that you got between the time you asked for your appeal and the time that the Grievance and Appeal Committee makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost.

Check this box if you would like to request the same services to continue during your appeal.

**Copy of your case file**

You have a right to a free copy of the information in your case file related to your appeal. Information means documents, records and other related material including any new or additional information Independent Care Health Plan gathers during your appeal.

Check this box if you would like to receive the information in your case file from Independent Care Health Plan related to your appeal.

\_\_\_\_\_  
**SIGNATURE – Member** \_\_\_\_\_  
Date Signed

Mail or fax this form to:  
Independent Care Health Plan  
1555 N River Center Dr, Suite 206  
Milwaukee WI 53212-3958  
Fax: 414-231-1090

To start your appeal as soon as possible, you can call Independent Care Health Plan at 414-231-1076 before mailing this form.

Your appeal must be postmarked or faxed no later than **60 calendar days** from the date on the Notice of Adverse Benefit Determination.

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

## **English**

**ATTENTION:** If you speak English, language assistance services are available to you free of charge. Call 1-800-777-4376 (TTY: 1-800-947-3529).

## **Spanish**

**ATENCIÓN:** Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-800-777-4376 (TTY: 1-800-947-3529).

## **Hmong**

**CEEB TOOM:** Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. Hu 1-800-777-4376 (TTY: 1-800-947-3529).

## **Chinese Mandarin**

**注意:** 如果您说中文, 您可获得免费的语言协助服务。请致电1-800-777-4376 (TTY 文字电话: 1-800-947-3529).

## **Somali**

**DIGTOONI:** Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa lagu heli karaa iyagoo bilaash ah. Wac 1-800-777-4376 (TTY: 1-800-947-3529).

## **Laotian**

**ໝາຍເຫດ:** ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-777-4376 (TTY: 1-800-947-3529).

## Russian

ВНИМАНИЕ: Если Вы говорите по-русски, Вам будут бесплатно предоставлены услуги переводчика. Позвоните по номеру: 1-800-777-4376 (TTY: 1-800-947-3529).

## Burmese

ဝက်းဇူးပူပီ၍ နားဆင့် - သင့်ည့် ပျမန္နာစကားပေ့ဟသူပူဖွါက၊  
သင့်အကြက အခဲပူဖင့် ဘာသာစကားကူညီေးရး ဝနဲဆာငွးမ်း  
ရရှိနိုင်ည။ 1-800-777-4376 (TTY: 1-800-947-3529) ကြင  
ဖနဲးေခင့ဆိုပါ။

## Arabic

تنبيه: إذا كنتم تتحدثون العربية، تتوفر لكم مساعدة لغوية مجانية. اتصلوا بالرقم  
4376-777-8001 (هاتف نصي: 3529-947-8001).

## Serbo-Croatian

PAŽNJA: Ako govorite srpsko-hrvatski imate pravo na besplatnu jezičnu pomoć. Nazovite 1-800-777-4376 (telefon za gluhe: 1-800-947-3529).

## Independent Care Health Plan

- 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 the Member Advocate/Member Rights Specialist at 1-800-777-4376, ext. 1076.