MEDICARE ADVANTAGE / MEDICARE PART D
APPEAL FORM

Please select your plan:

☐ Regence MedAdvantage (PPO/HMO)
☐ Regence Medicare Script™ (PDP)

Submit completed form to:
Medicare Advantage/Medicare Part D
Appeals and Grievance S5D
PO Box 12625
Salem OR 97309-0625

Name	Telephone Number (xxx) xxx-xxxx
ID Number	Provider Name
Date of Birth (mm/dd/yyyy)	Date of Service (mm/dd/yyyy)
Address	

Please feel free to contact us if you need additional assistance in completing this form. Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. Our toll-free number is 1 (866) 749-0355. TTY users should call 711.

Please explain your reason for filing this appeal: (attach additional sheets if necessary)

I hereby authorize my plan to obtain any medical records needed to review my appeal request. If applicable, this includes the release of information about alcohol or drug abuse, mental health, AIDS or HIV virus. This authorization begins on the date shown below and remains in effect so long as my request is being reviewed.

▶ _____ (mm/dd/yyyy) _____

Signature of Member or Authorized Representative * **Today's Date**

* Please attach documentation demonstrating your authority to act on behalf of another. This may include a Power of Attorney or Appointment of Representative form (Form CMS-1696).