



Appeal Form

Ask the Pre-Existing Condition Insurance Plan (PCIP) to review a decision

Instructions

Use this form if you do not agree with the factual eligibility decision PCIP made. You may ask PCIP to review the decision. **Fill out the form and mail it to PCIP within 30 days of the decision.** Cross out and correct any information that is wrong.

Questions?

If you have any questions about the form, call the Pre- Existing Condition Insurance Plan (PCIP): **1-877-428-5060**, Monday to Friday, 8 a.m. to 8 p.m. Or, on Saturday, 8 a.m. to 5 p.m. The call is free.

- Check this box if you disagree with the eligibility denial decision.
- Check this box if you disagree with the eligibility disenrollment decision.

A. Information about you.

MEMBER NUMBER:
 APPLICANT NAME:
 ADDRESS:
 CITY, STATE, ZIP:

DAY PHONE:

NIGHT PHONE:

B. Information about the person and the reason why coverage was denied or has ended.

C. Reason for review.

You **must** answer Questions #1 - #3 below. Question #4 is optional. Use extra paper if you need more space to write.

1. What is the decision you would like us to review?

Tell us the factual reason why you think our decision is wrong. Include any other information you think will be helpful. You may include a copy of the letter you received from PCIP that explains our decision.

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2. Why do you factually think that our eligibility decision is wrong?

Write your reason below. Or, check the boxes below. Check as many as you wish. Use extra paper if you need more space to write.

- | | |
|--|--|
| <input type="checkbox"/> You are a California Resident | <input type="checkbox"/> You sent us a denial letter or a letter showing that you were offered higher premium rates than the Major Risk Medical Insurance Program (MRMIP) PPO Product* |
| <input type="checkbox"/> You are a U.S. Citizen or U.S. National <u>and</u> sent documents showing your status* | <input type="checkbox"/> Your payment was received by the due date |
| <input type="checkbox"/> You provided your Social Security Number (SSN) because you are a U.S. Citizen/U.S. National | <input type="checkbox"/> Your premium should not be past due |
| <input type="checkbox"/> You lawfully reside in the U.S. <u>and</u> sent documents showing your status* | <input type="checkbox"/> You think our decision violates PCIP policy or law (explain below) |
| <input type="checkbox"/> Your Application was complete | <input type="checkbox"/> Other (explain below) |
| <input type="checkbox"/> You did not have health insurance coverage within the last 6 months | |

* Tell us below when you mailed or faxed in the documents.

3. What would you like us to do?

Write your reason below. Or, check the boxes below. Check as many as you wish.

- | | |
|--|--|
| <input type="checkbox"/> Be enrolled in PCIP | <input type="checkbox"/> Other (explain below) |
|--|--|

4. What else would you like us to know?

Is there any other information you think would help us review our eligibility decision? Write the information or send other papers that will help our review .

D. Sign the form and send it to us within 30 days of the decision.

Signature: ➔ _____ **Date:** _____

Mail the form and other papers to:

Pre-Existing Condition Insurance Plan
Review Unit
P.O. Box 537032
Sacramento, CA 95853-7032

Or, you can fax the form to:

Fax: 1-877-430-0843 The fax is free.

Write your Member Number on each paper you send
Your Member Number is: [MN]

E. Permission to share information with the following person:

I give permission for the PCIP program to give information over the telephone about the status of this appeal to the person listed below. This permission will end on the date the program mails the results of its decision regarding my appeal.

Person's Name: _____

Agent/Broker CA License Number (if applicable): _____

Applicant's Signature: ➔ _____ Date: _____