



Standard Request for Reconsideration Form

DATE OF REQUEST: _____

NAME: _____

ADDRESS: _____

Phone Number: _____ ID Number: _____

What decision would you like Gateway Health Plan Medicare Assured[®] HMO SNP to reconsider?

Please be specific and include as much information as possible, such as dates of service, the name of the provider, the name of the service in question, etc.

Have you already received this service? Yes No

If you answered yes, what was the date of service? _____

Do you have any additional information that you would like Gateway Health Plan Medicare Assured[®] to review? If so, please explain.

Would you like to attend or participate in a hearing? Yes No

Gateway Health Plan Medicare Assured[®] is a Medicare approved Special Needs Plan for individuals who have both Medicare and Medical Assistance

I would like to attend in person.

I would like to participate by phone.

Your rights during the grievance process:

- You (or your appointed representative) have the right to submit evidence or allegations of fact or law, in person or in writing.
- You (or your appointed representative) have the right to review any information related to the grievance process.
- You (or your appointed representative) have the right to have a Gateway Health Plan *Medicare Assured*[®] staff member assist you in this process.

Please review the information on this form to be sure that the information is correct. Make any corrections that you feel are needed. You may also wish to provide additional information for reconsideration.

Please sign this form and return it in the enclosed envelope.

Signature

Date

Printed Name

PLEASE NOTE: *If anyone other than the member has completed and signed this form, an Appointment of Representative Form must also be completed.*

You may obtain a copy of the Appointment of Representative form from our website (www.gatewayhealthplan.com) or by calling the number below.

Gateway Health Plan *Medicare Assured*[®] Member Services Department is available 8:00 a.m. to 8:00 p.m. seven (7) days a week. Members should call 1-800-685-5209. TTY users should call 711.

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