Appeal Form

If you wish to file an appeal, please complete this form. If you choose not to complete this form, you may write a letter that includes the information requested below. The completed form or your letter should be mailed to:

Home State Health Plan
Appeals Department
16090 Swingley Ridge Road
Chesterfield, MO 63017

Phone 1-855-694-4663 TDD/TTY 1-877-250-6113
Fax 1- 877-309-6762

Member's Name:_____

MO HealthNet #:_____

Street Address: _____

_____
City State Zip

Member Phone Number:_____

Tracking Number (if applicable. Found in upper left hand corner of denial letter):

_____

Additional information to support the appeal, (or attach):

_____

_____

_____

_____

_____

Signature of Member or Representative: _____

_____

Daytime Phone #:_____**Date:**_____

*** Relationship to Member:** ☐**Self** ☐**Parent** ☐**Guardian** ☐**Other**
If "other" explain_____