XO Health

Member Appeal Form

Note:

Filling out this form is completely optional. If you'd like to request a review, you or your authorized representative can simply call our Member Services team at the phone number on your Member ID card. Alternatively, you can send a written request to the address provided at the end of your Explanation of Benefits (EOB) or other correspondence you've received from XO Health.

Primary Member Information (This information can be found on the front of your ID card.)

Today's Date (MM/DD/YYYY)	**XO Health Member's ID Number**	**Member's Group Number** (Optional)

Member's Full Name

Birth Date (MM/DD/YYYY)	**Member's Email Address**

Please provide the following information for the person you are submitting the request for.

Full Name	**Birth Date** (MM/DD/YYYY)

Relationship to the Person Requesting the Appeal

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Please Advise if the Appeal is Related to

☐ Pre-Service ☐ Post Service

Note:
If your selection is Spouse, Child (18 years of age older) or Other, please complete the attached Authorized Representative Form with your request.

Please provide the following information to help XO Health review & respond to your request.

Claim ID Number (If Post Service selected above)	**Reference Number** (If Pre-Service selected above)	**Service Date** (MM/DD/YYYY) (If Post Service insert date of services, if Pre-Service insert date of denial)

Explanation of Your Request (Please use additional pages if necessary.)

Member's Signature (or signature of Authorized Representative)

Note:

When submitting this form with your request please include:

- Bill and/or correspondence for these services.
- Any other helpful information.

You can send your request through:	
Mail	**Email**
XO Health Grievance & Appeals Department 565 Willowbrook Center Pkwy. Willowbrook, IL 60527	claim.appeals@xohealth.com

XO Health complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude, or treat people differently based on their race, color, national origin, sex, age, or disability. We provide free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation, or other services, call the number on your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal:

Online at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,
or at:
U.S. Department of Health and Human Services,
200 Independence Avenue SW., Room 509F,
HHH Building, Washington, DC 20201,
or at:
1 (800) 368-1019, or 1 (800) 537-7697 (TDD)
