AmeriHealth Caritas
New Hampshire

Request for an Appeal

www.amerihealthcaritasnh.com

Name:	Member ID number or Social Security number:

1. I disagree with AmeriHealth Caritas New Hampshire's decision to reduce, terminate, or deny my request for:

2. I would like to my appeal to take place:
   - ☐ By phone at the number I have provided here: _____
   - ☐ In person at the AmeriHealth Caritas New Hampshire office.

3. Please check the box that applies:
   - ☐ I will represent myself at the appeal.
   - ☐ I would like the following individual to represent me:

     Name: _____

     Relationship to you:_____

4. Please check the box that applies:
   - ☐ I would like my benefits to continue during the appeal process. (In order for benefits to continue, you must file this request within 10 days of this Request being mailed or by the effective date listed on the Request, whichever is later.)
   - ☐ I do not want my benefits to continue during the appeal process.

     I understand that if I choose to have my benefits continue during the appeal process and I lose my appeal, **I may be responsible for paying AmeriHealth Caritas New Hampshire back for the benefits** I received while the appeal was pending.

Signature:	Date:

Sign and send the form to:

AmeriHealth Caritas New Hampshire
Attn: Appeals Department
25 Sundial Avenue, Ste 130 West
Manchester, NH 03103

Fax: **1-833-810-2264**