APPEAL FORM

This form is to help you file an appeal. You can fill it out and send it to us. Or, you may write a letter and include this information in your letter. Please mail or fax this form or your letter to:

Nebraska Total Care Appeals
2525 N. 117th Ave
Omaha, NE 68164
Fax 1-844-655-0567

Behavioral Health Appeals:
Nebraska Total Care Appeals
PO Box 10378
Van Nuys, CA 91410-0378
Fax 1-866-714-7991

***You must file an appeal within 60 days from the date on the denial letter.**

PLEASE PRINT

Member's Name: _____

Member's ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Member Phone Number: _____

Authorization/Tracking Number (if you have one). Found in the upper left hand corner of letter. _____

Share information you have about the appeal.

_____

_____

_____

_____

_____

Member signature: _____ **Date:** _____

[SIGNATURE OF MEMBER, PARENT OR GUARDIAN*]

Relationship to member

☐ Self ☐ Parent ☐ Guardian* ☐ Power of Attorney*

*Documents showing Legal Guardianship or Power of Attorney must be provided to Health Plan