Member Appeal/Complaint Request and Assignment of Authorized Representative

Name of member for whom the appeal/complaint is being filed:	
Name of person filing appeal/complaint:	
Date:	**Member ID:**
Is this person the (check one): ☐ Policyholder ☐ Member (if different than Policyholder) ☐ Authorized Representative	
Contact information of the person filing the appeal/complaint **Complete mailing address:**	
Phone:	**Fax (if applicable):**
Communication by email is OK: ☐ **Email address (if box above is checked):**	
If person filing appeal/complaint is other than the member, the member must indicate authorization by signing here:	
Are you requesting an urgent appeal? ("urgent" means your life, health, or ability to maintain function is in jeopardy.) ☐ Yes ☐ No	
Briefly describe your dissatisfaction or why you disagree with our decision not to approve the requested service/benefit (you may attach additional information such as a physician's letter, bills, medical records, or other documents to support your claim):	

Send this form, your denial notice, and any supporting documentation to:

True Health New Mexico
Attn: Appeals and Grievances
2440 Louisiana Blvd. NE, Suite 601
Albuquerque, NM 87110
Fax: 1-800-747-9132
Email: Member-A-and-G@truehealthnewmexico.com

Be sure to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.