

### APPEAL REQUEST FORM

Received Date:    /    /  
                                 mm, dd, yyyy

**SECTION A: PERSONAL INFORMATION OF THE APPELLANT**

Name (Print):	Telephone number:	Contract number:
Address:	Date case filed:	Provider number (if applicable):
Email:		
Appeal requested by: <input type="checkbox"/> Member <input type="checkbox"/> Legal guardian <input type="checkbox"/> Provider <input type="checkbox"/> Representative- relationship with member: _____	PMG number:	Primary physician provider (if applicable):

**SECTION B: APPEAL FILED DUE TO:**

Member name (Print):	Contract number:	Primary physician provider (if applicable):
Current Procedural Terminology (CPT):	Denied service description:	

**SECTION C: DESCRIPTION OF THE EVENTS RELATED TO THE APPEAL (Include documents that support your case like study results, medical order or any other document needed to work your case efficiently) You can continue in a new page if more space is needed.**


I certify that I have read, or the person designated by me, the description of the facts that appear in this section and they are in accordance with the truth, and I agree with what has been described.

Member or Representative or Provider's signature

Witness signature (if applicable)



Name of Service Representative

Service Representative Signature



**\*\*Complete all the applicable fields and sign this form, you can bring it to a Regional Office near your home, send by regular mail, fax, or email ([details below](#)).**

**INSTRUCTIONS: How to ask for a grievance or an appeal with PSM?**

**Step 1:** You, your representative, or your physician [*provider*] acting on your behalf (authorized in written by you) can request a grievance or an appeal. Your *written* request must include:

- Your name, member ID, contract number, and address
- Reasons for your grievance or appeal
- Any evidence you want us to review, such as medical records, provider's letters, or other information that explains why you need the item or service. Ask your physician for this information.

## How to Submit your Complaint, Grievance or Appeal:

Please submit this completed form by mail, email, in person, or fax:

### By Mail:

Attention: PSM Grievances &  
Appeals Department  
PO Box 364128  
San Juan, PR 00936

### By fax:

Attention: PSM Grievances &  
Appeals Department

**Tel. 787-332-0928**

### By Person:

PSM Service Centers in Caguas, Fajardo, Guayama, Humacao, Ponce, Aibonito, Cayey, Cidra, Coamo y Comerío. Please call our Service Line for physical address.

### By email:

vitalgrievancesandappeals@planmenonita.com

You can use the attached form, or you may write a letter including all the details.

This form is available in our website [www.menonitavital.com](http://www.menonitavital.com).

This format is available in alternative formats, such as large print, braille, or audio.

This form is also available in other languages, and PSM will provide oral interpretation services into any language other than English, if needed. Such a translation is at no cost to you.

If you need more information, or assistance to file a Complaint, Grievance or Appeal, please call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). Available Monday through Friday from 7:00 AM to 7:00 PM. This phone call is free. Upon request, interpreter services are also available.

You also have a right to present grievances before at the Patient's Advocate Office (OPP) or in the Puerto Rico Health Insurance Administration (ASES).

### Contact information for the OPP:

Telephone: 787-977-1100 (Metro Area) 1-800-981-0031 (toll free)  
Fax: 787-977-0915

### Contact information for ASES:

Telephone: 787-474-3300 (Metro Area) 1-800-981-2737 (toll free)  
Fax: 787-474-3348

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 1-866-600-4753 (TTY: 1-844-726-3345).

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-866-600-4753 (TTY: 1-844-726-3345) al 1-866-600-4753 (TTY: 1-844-726-3345).

**注意：**如果您使用繁體中文，您可以免費獲得語言援助服務。請致電（TTY: 1-866-600-4753; 1-844-726-3345）。

PSM cumple con las leyes estatales y federales aplicables de derechos civiles y no discrimina por razón de raza, edad, color, origen de nacionalidad, discapacidad o sexo.

**Este documento puede estar disponible en formatos alternativos como letra grande, audio u otros idiomas. Si necesita recibir estos servicios, llame al 1-866-600-4753 y 1-844-726-3345 TTY (audioimpedidos).**