Connect Nevada: Strengthening Youth, Empowering Families
Appeal Request Form

Today's Date:

An appeal is when you ask someone to take another look at a decision they made about your child/youth's services, like if they said no to something or reduced it. If you disagree with what Magellan of Nevada decided about your child/youth's services, use this appeal form within 60 days of getting the first letter saying no.

Authorization Number:

Appeal Urgency: Standard | Appeal Type: Choose One

Date(s) of Services you are appealing (Start Date) | (End Date)

Provider Name: | Service Location:

Child/Youth's Information

Child/Youth's Name (First, MI, Last):

Street Address:

City: | State: | Zip Code:

Phone Number: | Email:

Parent/Guardian (Name): | Phone Number:

(1) Tell us why you do not agree with our denial decision and (2) why you are filing the appeal

To make your appeal stronger, include proof like the denial letter, medical records, notes from the doctor, test results, and any other documents that can help. Send these documents with the appeal form.

(3) Child/Youth Consent for My Provider to File an Appeal on my Behalf

(Complete the Child/Youth's Freedom of Choice & Consent Form - Send back to us)

The Child/Youth gives Choose One consent for to file this appeal on

(4) Authorized Representative Information

You can ask someone to assist you with your appeal, like your healthcare provider. If you decide to do this, please let us know below and fill out the Authorized For Use and Disclosure Form, then send it back to us. This way, we can share the same appeal information with that person as we do with you, unless you ask us to stop.

Representative Name (First, MI, Last):

Street Address:

City: | State: | Zip Code:

Representative Phone Number: | Email:

Relationship to Member:

(5) You, the Child/Youth's Parent/Legal Guardian/Authorized Representative/Provider, need to sign this form

Signed: | Date:

Mail, Email, or Fax this Appeal Request Form, Appeal Supporting Documents, Member Consent Form, and/or Authorized Use and Disclosure Form to:

Attn: Magellan of Nevada - Appeals & Grievances Department

- P.O. Box 34028, Reno, NV 89533
- Email: NevadaAppealsGrievances@Magellanhealth.com
- Fax: 1-888-656-5426

Please call our Customer Experience Associates (8:00 a.m. – 5:00 p.m. PST) if you have questions or need help with completing this Appeal Request Form.

- Telephone:1-833-396-4310
- TTY: 7-1-1
- MagellanofNevada.com

SAVE FORM | PRINT | EMAIL TO QUALITY | CLEAR FORM

Discrimination is against the law

Magellan* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Magellan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Magellan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact your Magellan member service center 1-833-396-4310.

If you believe that Magellan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator, Corporate Compliance Department
8621 Robert Fulton Drive
Columbia MD 21046
Phone: 800-424-7721 (TTY 711)
compliance@magellanhealth.com

You can file a grievance by mail or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available athttps://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

*Magellan refers to all applicable subsidiaries and affiliates of Magellan Health, Inc., including but not limited to Magellan Healthcare, Inc, and its subsidiaries.

English	ATTENTION: If you speak english, language assistance services, free of charge, are available to you. Call 1-877-543-3875 (TTY: 1-800-456-4006).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-543-3875 (TTY: 1-800-456-4006).
Chinese	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 1-877-543-3875 (TTY: 1-800-456-4006)。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-543-3875 (TTY: 1-800-456-4006).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-543-3875 (TTY: 800-456-4006)
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-543-3875 (TTY: 1-800-456-4006) 번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-543-3875 (TTY (հեռատիպ)՝ 1-800-456-4006):
Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-543-3875 (TTY: 1-800-456-4006) تماس بگیرید.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-543-3875 (TTY: 1-800-456-4006).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-543-3875 (TTY: 1-800-456-4006)まで、お電話にてご連絡ください。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 877-543-3875 (رقم هاتف الصم والبكم: 1-800-456-4006).
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-877-543-3875 (TTY: 1-800-456-4006) 'ਤੇ ਕਾਲ ਕਰੋ।
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-543-3875 (TTY: 1-800-456-4006)។
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-543-3875 (TTY: 1-800-456-4006).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-543-3875 (TTY: 1-800-456-4006) पर कॉल करें।
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-543-3875 (TTY: 1-800-456-4006).