



Iowa Health Link  
Iowa HHS

### Request for Appeal Form

To ask for an appeal, please fill out and mail us this form. It will help us understand your request. We will send you a letter within three business days to let you know we received the form. We will send you a letter within 30 calendar days after we get the form to let you know what we decide.

Member name: \_\_\_\_\_

Parent's or guardian's name (if service is for a child): \_\_\_\_\_

Wellpoint Iowa ID#: \_\_\_\_\_

Reference Number: \_\_\_\_\_

Name of provider who wants to give or who gave you the service: \_\_\_\_\_

Provider office address: \_\_\_\_\_  
\_\_\_\_\_

Provider office phone number(s): \_\_\_\_\_ / \_\_\_\_\_

Type of service you want: \_\_\_\_\_  
\_\_\_\_\_

Why you want the service: \_\_\_\_\_  
\_\_\_\_\_

Have you received the service?  Yes  No

Type of service you received: \_\_\_\_\_

Why you received the service: \_\_\_\_\_

Date you had or want to have the service: \_\_\_\_\_

Why you are asking for an appeal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sign and send this form to:**  
Member Grievances and Appeals  
Wellpoint Iowa, Inc.  
4800 Westown Parkway, Ste. 200  
West Des Moines, IA 50266

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Member, parent, legal guardian or authorized representative\*

\*An authorized representative must be named by the member, parent or legal guardian. The provider may act on behalf of the member with the member's/responsible party's written consent. An authorized representative cannot make healthcare decisions that involve the financial duty of the member, parent or legal guardian unless the member gives his or her OK in writing.

If you need help, please call Member Services toll free at 833-731-2140 (TTY 711), Monday through Friday, 7:30 a.m. to 6 p.m. Central time, except holidays.

Enclosures: Get help in another language  
Nondiscrimination notice