FirstChoice
by Select Health of South Carolina
Your Hometown Health Plan

Healthy Connections

Member Appeal Request Form

Healthy Connections ID #: _____
Appeal date: _____
Member name: _____

Reason for appeal:

_____

_____

_____

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_____

_____

_____

Member signature _____ Date _____

or

Authorized representative signature* _____ Relationship to member _____ Date _____

Signature of First Choice representative who handled verbal request for appeal _____ Date _____

Return to:

First Choice Member Services
P.O. Box 40849
Charleston, SC 29423-0849

*To serve as an authorized representative on behalf of a member you must also attach the member's written consent.

FC-02152016-M-002.2_clean