

Return this form by Mail or Fax:
ODS Appeal Unit
601 SW Second Avenue
Portland OR 97204
Fax (503) 412-4003



ODS OHP APPEAL FORM

Name of Person Filing Complaint Telephone#

Address City State Zip

Member Name Patient Name Member ID#

Name of Provider Involved Address Telephone#

Name of Provider Involved Address Telephone#

Date(s) of Service

- Appeal: I want to appeal the denial.**
- Expedited (fast) Appeal:** I want a fast appeal because I feel taking the time for a regular appeal will greatly harm my life, health, or ability to function.
- Continue Benefit:** I would like to continue receiving the service I was getting before the date of notice of action. I understand that if I lose the appeal, I may have to pay for the services I got during the appeal. I understand that continued benefits may be delayed if I do not request an appeal within 10 days of the **“effective date”** shown on the denial letter.

Please write the reason for your appeal in the space below. There is more space on page 2. Use additional pages if needed. You may include medical records, letters or bills which will help us investigate your appeal. **Please sign and date this form.**

Signature: _____

Date: _____

After we receive your appeal ODS will mail you a letter to show that we got it.

