Exclusive Care
The Exclusive Provider Health Plan of the County of Riverside

Request for Appeal of Denied Services

For Exclusive Care Only
Date Received:
Date Acknowledgement Sent:
Final Response Sent:

Exclusive Care Member Information	
Member Name:	Member ID Number:
Home Address:	Member Phone Number:
City, State Zip:	
Medical Condition or Symptom:	
Did this request involve an Urgent Care? ☐Yes ☐ No	
Urgent Care Name:	

A referral or authorization from your physician for services request was previously reviewed and denied. If you believe your preauthorization request or claim was denied in error, you may appeal this decision. You have 180 days after receiving the denial to appeal the Plan's decision. You may submit written comments, documents, or other information to the Plan in support of your appeal and have access, upon request, to all relevant documents free of charge.

Your appeal rights are documented in the Summary Plan Description, pp45-52

Please provide written comments, documents, and other information to the Plan in support of your appeal. When complete, FAX or MAIL all pages to the address below. You will receive notice of our decision within 30 days of receipt of your appeal.

Please contact us if you need and further information or assistance: (800) 962-1133, option #3
(Additional pages may be attached as needed)

_____ _____

Signature Date

I certify that the information on this form is correct to the best of my knowledge and authorize the release of any medical information necessary to process this appeal of denied service(s).

Please submit Appeal of Denied Service(s) form via Email, Fax, or Mail		
Email: ecreferrals@rivco.org	Fax: (951) 955-0035	Mail: Exclusive Care Health Plan Attn: Medical Management Po Box: 1508 Riverside, Ca 92502-1508