

## **Internal Appeal Request**

An action is when CMHA-CEI has denied, reduced, suspended, or terminated a covered benefit (service). If you don't agree with our action, you have the right to an Internal Appeal.

If you need assistance with filling out this form, please contact Customer Service at:

## 517-346-8244 or toll free at 1-877-333-8933.

Please send completed forms to: CMHA-CEI QCSRR – Compliance 812 E. Jolly Road Ste. 108 Lansing, MI 48910

	Lansing,	MI 48910
Date:	Consumer Name:	Date of Birth:
Phone:	Address:	
	the box below, that best fits your requirements $Ex_i$	pedited Internal Appeal (life threatening)? est.
	I Internal Appeal I Internal Appeal (life threatening)	
Reason for R	equest of Internal Appeal: (attach addit	ional sheets if needed):
Consumer or	Legal Guardian Signature:	Date
		uired) 
If you want s	someone else to act for you, you can na	ame a relative, friend, attorney, doctor, or someone one else to act for you, please fill out this section:
Acting Repre	sentative Name:	
Acting Repre	sentative Address:	
Acting Repre	sentative Phone Number:	
Acting Repre	sentative Signature:	
	(Required if there is an	Acting Representative)