700 Main Street, Suite 100
Alamosa, CO 81101

Member Appeal/Complaint Request and Assignment of Authorized Representative Form

Send this form, your denial notice, and any supporting documentation to:
Friday Health Plans Appeals Coordinator
700 Main Street, Suite 100
Alamosa Colorado 81101

Name of member for whom the appeal/complaint is being filed:	
Is the above named (check one): ☐ Policy Holder ☐ Member (if different than policy holder) ☐ Authorized Representative	
Date:	Member ID:
Name of the individual filing the appeal/complaint (if different than above):	
Mailing address where the person filing can be reached:	
Phone:	Fax (if applicable):
☐ Communication via email is preferred (list email below):	
If person filing appeal/complaint is NOT the member, the member **MUST** indicate authorization by signing below:	
Are you requesting an urgent appeal? ("Urgent" is defined as an immediate threat to your life, health, or ability to maintain function is in jeopardy.) ☐ Yes ☐ No	
Briefly describe your dissatisfaction or why you disagree with our decision not to approve the requested service/benefit: (you may attach any additional information such as a physician's letter, bills, medical records, or other documents to support your claim):	

For questions:
Phone: 1-800-475-8466
Fax: 1-844-280-1794
Email: appeals@fridayhealthplans.com