



**MAPD Appeal Request
(REDETERMINATION)**

Please fax completed form and medical records to: 813-506-6151

You may reach us by phone at 1-800-401-2740 for any questions

Please complete each section legibly.

Member Name	Date of Request	Requester's Name & Relationship To Member
Plan ID#		County of Member's residence:
DOB		Physician Name
Diagnosis		Specialty
Drug Name		Contact Person
Dose		Physician's Phone
Dosage Form/Strength		Physician's Fax
Qty		Pharmacy Phone
Length of Treatment		
Clinical Reason for Appeal (include medical documentation)		
History/Allergies	Freedom Health use only: RD _____ DD _____ Tech_ _____ date _____ RPh _____ date _____ MD _____ date _____	

Instructions for submitting a MAPD Appeal Request (Redetermination form):

Providers may return completed forms by fax or mail.

Fax number: 813-506-6151

Mailing Address:

Freedom Health, Inc., Attention: Grievance and Appeals Department,

PO Box 152727, Tampa, FL 33684

If providers have any questions when completing this form they should call Freedom Health at 1-800-401-2740 (for TTY, call 1-800-955-8771), Monday - Friday 8:00am-8.00 PM EST.