



PO Box 2917  
Shawnee Mission, KS 66201-1317  
Phone: 800-650-1745

### HEALTH CARE APPEAL REQUEST FORM

*You may use this form to tell your insurer you want to appeal a denial decision.*

Insured Member's Name \_\_\_\_\_ Member ID # \_\_\_\_\_  
Name of representative pursuing appeal, if different from above \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Phone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Type of Denial:  Denied Claim  Denied Service Not Yet Received

Name of Insurer that denied the claim/service: \_\_\_\_\_

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? \_\_\_\_\_

\_\_\_\_\_

*(Explain what you want your insurer to authorize or pay for.)*

Explain why you believe the claim or service should be covered:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Attach additional sheets of paper, if needed.)*

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548, or Insurance Benefit System Administrators at (800) 650-1745.

**Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including:**  Medical records  Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) **\*\*Also attach the certification from your treating provider if you are seeking expedited review.**

\_\_\_\_\_  
Signature of insured or authorized representative

\_\_\_\_\_  
Date