[Insurers may insert an address block directing insureds to submit this form to a specific address.]

HEALTH CARE APPEAL REQUEST FORM

You may use this form to send to your insurer to tell them you want to appeal a denial

Insured Member's Name _____ ID # _____
Name of representative pursuing appeal, if different from above_____
Mailing Address _____
City _____ State ____ Zip Code _____
Phone # _____ Email: _____

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 and Financial Institutions Consumer Services number (602) 364-2499, or [name of insurer] at _____.

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 and supporting documentation from your treating provider if you are seeking expedited review.

_____ _____
Signature of insured or authorized representative Date