REQUEST FOR REVIEW

ADVERSE BENEFIT DETERMINATION
(CLAIM DENIAL/INFORMATION NEEDED)

Please complete the information in the spaces below, including your signature and the date.

Participant's Name: _____

Claimant's or Patient's Name: _____

Name & Relationship of Person Filing for the Request for Review (include Appointment of Authorized Representative, if not Claimant): _____
_____

Contact Information

Mailing Address: _____
Daytime Telephone Number: _____
Email Address: _____

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim). _____
_____
_____

Signature: _____
Date: _____

Send this form and your Claim Denial Notice to the Director of Employee Benefits at your employer's corporate headquarters.

It is advisable that you keep copies of this form, your claim denial notice, and all documents and correspondence related to this claim.