INDIANA TEAMSTERS HEALTH BENEFITS FUND

6007 S. Harding St.
Indianapolis, Indiana 46217
Phone: (317) 639-3573
Fax: (317) 639-3548

CLAIMS APPEAL FORM

PRINT ONLY

PATIENT'S NAME: _____ ADDRESS: _____
MEMBER'S NAME: _____ _____
POLICY HOLDER'S ID# _____ PHONE #: _____
EMPLOYER'S NAME: _____

PROVIER'S NAME: _____ DOLLAR AMT. APPEALING: $ _____
PHONE #: _____ DR'S NAME: _____
DATE(S) OF SERVICE: _____

REASON FOR APPEAL: (GIVE A FULL DESCRIPTION)

_____
_____
_____

(PLEASE USE BACK OF THIS PAGE FOR ADDITIONAL COMMENTS)

LIST THE ADDITIONAL DOCUMENTATION ENCLOSED FOR YOUR APPEAL:
(EXAMPLES OF ADDITIONAL DOCUMENTATION ARE MEDICAL RECORDS, PHOTOGRAPHS, OPERATIVE REPORT, LETTER FROM YOUR PRESCRIBING PHYSICIAN)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

THE FUND USES A SINGLE LEVEL OR A TWO-LEVEL APPEAL REVIEW PROCESS. YOU WILL RECEIVE NOTICE OF THE TRUSTEES' DECISION ON APPEAL AS SET FORTH IN THE PLAN DOCUMENTS. THE LAST DECISION ON REVIEW WILL BE THE FINAL AND BINDING.

SUBMIT COMPLETED FORMS AND ANY SUPPORTING DOCUMENTATION TO:

INDIANA TEAMSTERS HEALTH BENEFITS FUND
PRIVACY OFFICER
ATTN: APPEALS CLERK
6007 S. Harding ST.
INDIANAPOLIS, IN 46217

SIGNATURE: _____ DATE: _____

ALL INFORMATION IS SECURE AND MAINTAINED UNDER THE HIPAA PRIVACY ACT