



Request for Internal Appeal

You have the right to appeal adverse benefit determinations. These may include:

- Determinations of ineligibility to participate in the plan
- Determinations that certain services are not covered
- Rescission of coverage
- Determinations that certain treatments are not medically necessary
- Termination of your membership in this plan

You must submit your appeal within 180 days of the adverse benefit determination.

Patient Name: _____	Patient DOB: _____
Subscriber Name: _____	Subscriber ID: _____

Services in Dispute

Claim Number: _____

Have you already received these services? ☐ Y ☐ N Date(s) of Service: _____

Provider Name: _____ Provider Address: _____

Please state the reason you believe the decision was incorrect (you may also attach a letter of explanation):

In addition to this form, you can submit any additional documents or information that support the appeal, if available. This may include:

- A letter or prescription from your doctor
- A receipt for money you paid
- Relevant excerpts of medical records

Signature: _____ Date: _____

I am the: ☐ Patient / Subscriber ☐ Parent / Legal Guardian ☐ Authorized Representative

*If you are not the Plan Participant and are not authorized to act on the Participant's behalf pursuant to the terms of the Plan, you must submit valid documentation of the Participant authorizing you to appeal on their behalf. Please contact Collective Health if you would like a copy of the authorization form.