**ORANGE – ULSTER**
**SCHOOL DISTRICTS**
**HEALTH PLAN**

DATE: _____

# APPEALS PROCEDURE FORM

(To be completed by the Plan member)

School District: _____

School District Representative: _____

Patient Name: _____

Employee Name: _____Social Security #_____

Address: _____
(Street)

_____
(City (State) (Zip Code)

CLAIM # DATE OF SERVICE PROVIDER

_____

List the section and page of the Plan Document that applies to this Appeal:

_____

Write a clear and concise narrative describing the Appeal, use additional paper if necessary.
Attach all relevant documentation.

_____

_____

_____

_____

_____

_____

_____

Plan Member Signature: _____

School District Plan Representative:_____
(Signature – required)

*(06-2012)*