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)