

*PARTICIPANT INFORMATION*

Participant Name \_\_\_\_\_

Social Security # \_\_\_\_\_

MID # \_\_\_\_\_ Plan # \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

*EMPLOYER/APPEAL INFORMATION*

Employer \_\_\_\_\_

Date of Appeal \_\_\_\_\_

Base Month *(based on hours/day(s) worked)* \_\_\_\_\_

Coverage Month/Month of Appeal \_\_\_\_\_

*PLEASE WRITE YOUR APPEAL LETTER/EXPLANATION BELOW*

To the Appeals Subcommittee: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

<b>For Office Use</b>	<b>TYPE</b>	<input type="checkbox"/> Self payment <input type="checkbox"/> Retiree dental/medical <input type="checkbox"/> IPNL/EDNL/D&L	<input type="checkbox"/> Employee contribution <input type="checkbox"/> DP tax payment	<input type="checkbox"/> COBRA <input type="checkbox"/> Disability
	<b>GRANT</b>	<input type="checkbox"/> First appeal in 12 months <input type="checkbox"/> Wrong address	<input type="checkbox"/> Second appeal in 12 months <input type="checkbox"/> Physical/mental incapacity	<input type="checkbox"/> Lag months <input type="checkbox"/> Away from residence
	<b>REFUSE</b>	<input type="checkbox"/> Third appeal in 12 months <input type="checkbox"/> Max eligibility	<input type="checkbox"/> Exceeds 12 month rule <input type="checkbox"/> Self-pay abuse	<input type="checkbox"/> NSF
	<b>OTHER</b>	_____		
	<b>PAYMENT</b>	<input type="checkbox"/> Check (# _____ )	<input type="checkbox"/> Money Order	<input type="checkbox"/> Credit Card