

NOTICE OF APPEAL



Before filing this appeal, please contact the MedBen Customer Service Department, unless you have already done so. They may be able to provide you with additional information or resolve your complaint for you.

Full Name of Employee/Primary Insured (Participant): _____

Insured (Participant) Social Security/Identification Number: _____

Individual whose Claim/Precertification is subject of Appeal (Claimant): _____

Relationship of Claimant to Participant: _____ **Is Claimant a Minor?** Yes No

MedBen Group Number: _____ **Name of Employer:** _____

Health Plan is:

- Fully Insured through Medical Benefits Mutual Life Insurance Co. *Return form to: Appeals Committee, Medical Benefits Mutual Life Insurance Co., P.O. Box 1009, Newark, Ohio 43058-1009*
- Self-funded and administered by Medical Benefits Administrators, Inc. *Return form to: Appeals Committee, (plan name), c/o Medical Benefits Administrators, Inc., P.O. Box 1099, Newark, Ohio 43058-1099*
- Administered by VisionPlus of America, Inc. *Return form to: Appeals Committee, VisionPlus of America, Inc., P.O. Box 1009, Newark, Ohio 43058-1009*

Name of Individual filing Appeal: _____

Relationship to Claimant: _____

If Individual filing Appeal is other than Claimant or Parent/Legal Guardian of a Minor Child, attached "Designation of Authorized Representative" must be completed by the Claimant and Section 1 on reverse should be completed. If filed as an urgent care appeal, designation form is not required if appeal is filed by an attending physician who is familiar with the Claimant's condition. If appeal is filed by the Claimant or Parent/Legal Guardian of a Minor Child, Section 2 on reverse should be completed.

Have the requested Services/Supplies which are the Subject of this Appeal already been provided to the Claimant? Yes No When were such services or supplies provided, or when are they scheduled to be provided?: _____

Appeal Involves:

- Complete or partial denial of request for precertification
- Complete or partial denial of claim
- Eligibility Issue
- Other: _____

Briefly describe the health plan determination which is the basis of the appeal (attach additional sheets, if necessary): _____

Claim Number(s) Related to Appeal: (see Explanation of Benefits) _____

Why do you believe that this determination was incorrect? (attach additional sheets, if necessary) _____

List a chronology of all contacts made with MedBen or representatives of your health plan regarding this claim/precertification, including how the contact was made, date, who made the contact, the MedBen representative involved and the result of the contact (attach additional sheets, if necessary): _____

- I hereby request that this appeal be treated as an “urgent care” appeal on an expedited basis. I understand that such a request can only be made prior to the time the services or the supplies are provided, and that, if such services or supplies are provided prior to the time this appeal is decided that it would no longer be treated as one involving urgent care. (In order to qualify as an urgent care appeal, your attending physician must certify that your condition is such that treatment of this appeal on an expedited basis necessary).

CERTIFICATION OF ATTENDING PHYSICIAN

I hereby certify that I have treated the claimant listed above, and that his/her current condition justifies the processing of this appeal on an expedited basis for the following reason(s): _____

Dated: _____ Signed: _____
Claimant’s Attending Physician

- 1** I certify that I am properly authorized to file the above appeal, and that the information provided above is correct, to the best of my knowledge and belief.

Dated: _____ Signed: _____
Individual Filing Appeal (If Other Than Claimant)

- 2** I certify that the information provided above is correct, to the best of my knowledge and belief.

I authorize any medical providers or other parties to release to MedBen, any and all medical records and information regarding my medical condition, diagnosis, treatment, prognosis, care, and/or hospitalization which is relevant to this appeal. Such information includes case management notes, psychotherapy notes, medical utilization notes, clinical patient data, medical opinions and evaluations, including information from the health care providers which has been accumulated by the medical providers during the care of the undersigned. The information released pursuant to this authorization is to be used for the purpose of reviewing and deciding issues which are relevant to the subject of this appeal.

I understand that if I fail to provide this authorization, MedBen will be unable to process my appeal. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer of my health plan at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen’s receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law.

This authorization is effective on the date signed and shall remain in effect for the duration of the undersigned’s appeal under the MedBen insured plan or the employer’s employee health benefit plan. A photocopy of this authorization shall be as valid as the original. The undersigned, and any individual authorized by law to act on behalf of the undersigned, shall have a right to receive a copy of this authorization.

I also understand that information relative to this appeal may be provided to the Plan Administrator of my Health Plan, which may be the employer sponsoring the plan, if my Health Plan is self-funded.

Dated: _____ Signed: _____
Claimant
(or Parent/Legal Guardian of Claimant, if a Minor)

**DESIGNATION OF
AUTHORIZED REPRESENTATIVE
FOR APPEAL**



I hereby authorize _____ to file an appeal on my behalf regarding _____ and to act as my representative in all matters regarding this appeal. I request that MedBen (*Medical Benefits Mutual Life Insurance Co., Medical Benefits Administrators, Inc. or VisionPlus of America, Inc.*) direct all correspondence regarding this appeal to this individual at the following address: _____

Pursuant to this authorization, I request that MedBen release any information to my designated representative, any and all information which is relevant to this appeal, including, but not limited to, medical records and information regarding the undersigned's medical condition, diagnosis, treatment, prognosis, care, and/or hospitalization. Such information may include case management notes, psychotherapy notes, medical utilization notes, clinical patient data, medical opinions and evaluations, and information from the undersigned's health care providers which has been accumulated by MedBen on its own behalf as an insurer, or as third party administrator for my employer sponsored self-funded plan, as well as claims, claims payment, and eligibility information. The undersigned understands that upon signing and returning this document, such information and records will be released by MedBen, to said authorized representative at various times, as requested by said authorized representative.

I understand that information disclosed by MedBen to any individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals, and will no longer be protected by this authorization. I understand that if I fail to provide this authorization, MedBen will be unable to process my appeal. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer of my health plan. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen's receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law.

The undersigned hereby agrees to indemnify and hold MedBen harmless from any and all claims, lawsuits, settlements, judgments, costs, penalties and expenses, including attorneys fees, for releasing such information and records pursuant to this document.

I further authorize any medical providers or other parties to release to MedBen, any and all medical records and information regarding my medical condition, diagnosis, treatment, prognosis, care, and/or hospitalization which is relevant to this appeal. Such information includes case management notes, medical utilization notes, clinical patient data, medical opinions and evaluations, including information from the health care providers which has been accumulated by the medical providers during the care of the undersigned. The information released pursuant to this authorization is to be used for the purpose of reviewing and deciding issues which are relevant to the subject of the appeal filed on my behalf on _____.

This authorization is effective on the date signed and shall remain in effect for the duration of this appeal under the MedBen insured plan or the employer's employee health benefit plan. A photocopy of this authorization shall be as valid as the original. The undersigned, and any individual authorized by law to act on behalf of the undersigned, shall have a right to receive a copy of this authorization.

I understand that this authorization does not cover any post appeal actions filed on my behalf, including, but not limited to, insurance department or other governmental agency complaints, court actions or other post appeal actions which are allowed under state or federal law. I further understand that if this individual is to continue to act on my behalf in these post appeal proceeding, another appropriate authorization may be requested.

I also understand that information relative to this appeal may be provided to the Plan Administrator of my Health Plan, which may be the employer sponsoring the plan, if my Health Plan is self-funded.

DATED this _____ day of _____, 201__.

Claimant