Public Education HEALTH TRUST

Appeal Form

This form and all relevant information may be submitted to:

Public Education Health Trust
Attn: Plan Administrator
4003 Iowa Drive, Anchorage, AK 99517

Phone: (907) 274-7526 – Fax (907) 222-2556

Office use only
_____ Date of denial of benefits
_____ Date first appeal received by EBMS
_____ Date of appeal decision by EBMS
_____ Date second appeal received
_____ Date of final determination
_____ APPEAL NUMBER

Your Information

Member Name		**Member I.D.**	
Patient Name		**Employer (District)**	
Street Address	**City**	**State**	**Zip Code**
Claim #		**Date of Service**	
Best Contact Number	**Alternate Number**	**Amount of Appeal** **$**	

Reason for Appeal (If additional space is needed, please use the back of this form, attach additional sheets and documentation as needed)

Check one or more of the following reasons for your appeal:

- ☐ Disagree with the amount paid on a claim or with the amount of member copayment
- ☐ Believe the claim was for a covered service and should not be denied for payment
- ☐ Believe a service was medically necessary, though denied as not medically necessary
- ☐ Eligibility issue. Please describe:_____
  _____
- ☐ Other. Please describe:_____
  _____
  _____

You may include the following documentation:

- ❑ Copies of the explanation of benefits and letters of denial
- ❑ Letters of medical necessity from physicians
- ❑ Supporting documentation from your summary plan description
- ❑ Notes of phone conversations supporting your appeal
- ❑ Documentation of research you have done to support your appeal

Please attach documents, other records, or additional commentary you wish to have considered on appeal.

Signature	**Date**

Appeal Rights

You have the right to appeal. You must file your appeal within 180 days of receiving a denial of benefits. EBMS must make an initial appeal determination within 30 days of receiving your written appeal. You also have the right to a second level appeal if you make the written request within 60 days of the first appeal determination. The Public Education Health Trust Plan Administrator must make the second appeal determination within 30 days of receiving your written request for second level appeal.

You have the right to examine or receive free copies of all pertinent Plan documents, records, and other information relevant to your claim.

- ❑ Yes, I wish to receive free copies of all the information relevant to my claim.
- ❑ No, I do not wish to receive free copies of all the information relevant to my claim.