En español al dorso

Culinary Workers Health Fund
APPEAL REQUEST

FOR OFFICE USE ONLY

IT# _____

APPEAL # _____

SECTION 1: PARTICIPANT INFORMATION

NAME OF PARTICIPANT: _____ NAME OF PATIENT: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

SOCIAL SECURITY NUMBER: _____ TELEPHONE NUMBER: _____ E-MAIL ADDRESS: _____

NAME OF EMPLOYER: _____ OCCUPATION: _____

LANGUAGE PREFERENCE: ☐ English ☐ Spanish ☐ Other _____

SECTION 2: SELF-PAY APPEAL

☐ 1st SELF-PAY APPEAL ☐ HAVE PREVIOUSLY FILED A SELF-PAY APPEAL ☐ OTHER _____

DATE SELF-PAYMENT WAS DUE: _____

Skip to SECTION 4 (sign and date) AND SECTION 5 (your explanation of what happened) to complete your appeal.

SECTION 3: CLAIM APPEAL

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LOSS OF TIME ☐ OTHER _____

NAME OF THE PROVIDER OF SERVICE FOR THE CLAIM BEING APPEALED: _____

DATES OF SERVICE FOR THE CLAIM BEING APPEALED: _____

CLAIM NUMBER (IF KNOWN), OR YOU MAY ATTACH A COPY OF THE EXPLANATION OF BENEFITS FOR THE CLAIM(S) BEING APPEALED:

PLEASE SIGN AND DATE SECTION 4 AND PROVIDE AN EXPLANATION OF WHAT HAPPENED IN SECTION 5 (PAGE 3)

SECTION 4: MUST sign and date at the bottom

IN ORDER FOR YOUR APPEAL TO BE PROCESSED, YOU MUST SIGN AND DATE THIS AUTHORIZATION TO RELEASE INFORMATION.

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide the H.E.R.E.I.U. Welfare Fund or an agency, attorney, claims investigative agency or independent administrator acting on its behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I authorize my employer or benefit plan administrator to provide the H.E.R.E.I.U. Welfare Fund with financial or employment related information.

I understand that such information may be used by the H.E.R.E.I.U. Welfare Fund or an agency, attorney, claims investigative agency, or independent administrator acting on its behalf, for all purposes related to evaluating, processing, and reviewing my claim or my dependent's claim for benefits, including examining the benefits provided by the H.E.R.E.I.U. Welfare Fund. I understand that I or any authorized representative will receive a copy of the authorization upon request. This authorization will be valid for the entire period of my eligibility and my dependent's eligibility under the H.E.R.E.I.U. Welfare Fund's plan of benefits.

I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

_____ _____

Signature of Employee or Other Authorized Person Date
(If Dependent Patient is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign)

Relationship to Employee

RETURN COMPLETED FORM TO:

CULINARY WORKERS HEALTH FUND
1901 LAS VEGAS BLVD. SOUTH SUITE 107
LAS VEGAS, NV 89104-1309
(702) 733-9938 www.culinaryhealthfund.org

REVISED 5/01/02

SECTION 5: APPEAL EXPLANATION - MUST provide explanation

PLEASE ADDRESS YOUR EXPLANATION TO THE CHAIRMAN OF THE LEGAL COMMITTEE, AND IN YOUR OWN WORDS EXPLAIN (a) THE REASON YOU ARE APPEALING, (b) WHAT YOU ARE APPEALING, AND (c) WHAT YOU WANT DONE. IF YOU PREFER, YOU CAN ATTACH A SEPARATE LETTER EXPLAINING YOUR APPEAL.

Dear Chairman of the Legal Committee:

RETURN COMPLETED FORM TO:

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LAS VEGAS, NV 89104-1309
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