Medical Appeal Form

St Luke's™ Health Plan

If you disagree with our decision to deny a claim or reduce medical benefits, use this form to request reconsideration. You are invited and encouraged to attach any documentation that supports your appeal, such as medical records, bills and notes from doctors. For pharmacy benefit denials or reductions, please use the **Pharmacy Appeal Form.**

Subscriber Name (First and Last):	**Patient Name** (person that is the subject of the appeal, First and Last):
Subscriber ID:	**Patient DOB:** **Claim or Ref ID:**
Street Address:	**Dates of Service:** _____ to _____
City:	**Phone:**
State: **Zip:**	**Email** (optional):
Preferred method of contact regarding this appeal: Phone ☐ Email ☐ Mail ☐	**Expedited/Urgent?** No ☐ Yes ☐ Expedited appeals are only available for services that have not yet been rendered.
Members over the age of 18 must either file their own appeal or formally appoint someone to represent them. To appoint someone to act on your behalf, complete, sign and submit a Designated Authorized Representative form. To access this form, visit our website at **stlukeshealthplan.org.**	

Why are you filing an appeal?

What is your desired outcome?

Consent

I give St. Luke's Health Plan permission to investigate my appeal, review medical records associated with the appeal, and talk to my doctor about my appeal.

Signature: _____ Date: _____

Relationship to patient: _____

Send completed forms via email or mail.

Questions? Call the customer service number on the back of your member ID card.

Email: slplanappeals@slhealthplan.org

Mail: ATTN: Appeals Coordinator, St. Luke's Health Plan, PO Box 1739, Boise, ID 83702-5809