

# Medical Appeal Form



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**.

|   |             |  |                         |
|---|-------------|--|-------------------------|
| <b>Subscriber Name</b> (First and Last):  |             | <b>Patient Name</b> (person that is the subject of the appeal, First and Last):  |                         |
| <b>Subscriber ID:</b>   |             | <b>Patient DOB:</b>  | <b>Claim or Ref ID:</b> |
| <b>Street Address:</b>  |             | <b>Dates of Service:</b><br>_____ to _____   |                         |
| <b>City:</b>  |             | <b>Phone:</b>  |                         |
| <b>State:</b>   | <b>Zip:</b> | <b>Email</b> (optional):   |                         |
| <b>Preferred method of contact regarding this appeal:</b><br>Phone      Email      Mail |             | <b>Expedited/Urgent?</b> No      Yes<br>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](http://stlukeshealthplan.org) or call Customer Service at **833-840-3600**.

## 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 Customer Service at **833-840-3600**.

Email: [slplanappeals@slhealthplan.org](mailto:slplanappeals@slhealthplan.org)

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