# MEDICAL, DENTAL OR PRESCRIPTION MEMBER APPEAL SUBMISSION FORM

## ASEA Health Benefits Trust

Address: 111 W. Cataldo, Suite 220, Spokane, WA 99201 • Phone: 866-553-8206 (toll-free); 509-328-0300 • Fax: 509-328-8623
Website: www.aseahealth.org

*Members*: Use this form to submit an appeal for denied medical or dental claims. You may also use this form to appeal a denial, after you have received care, for no pre-certification and/or no prior authorization. To appeal a prescription denial, you must first use Caremark's appeal process as described on their denial forms. If you have fully exhausted all appeal avenues with Caremark, please submit this form.

*Providers:* If you seek to appeal a denial for medical necessity or a denial of pre-certification, you must appeal directly to Aetna.

Please see your Plan Booklet for complete details about the appeal process. In order for the Board of Trustees to consider your appeal, it must be received by the Health Trust Administrator within 180 days of the date of the determination notice or the Explanation of Benefits (EOB).

Please complete the section below that pertains to your appeal. Submit your completed form and attachments securely through Contact Us, under Appealing a Denied Claim, on the Trust website (aseahealth.org). Or, you can fax or mail the form and your attachments to the ASEA Health Trust Administrator at the number or address shown above.

**PLEASE PRINT CLEARLY**

Employee name: SSN or Alternate ID:

Mailing address:

Email (optional): Phone #:

Patient name: Patient date of birth:

Denial reason (from EOB): ❑ UCR Limit ❑ Multiple Surgery Rule ❑ Exceeds Plan Limit ❑ Experimental/Investigational ❑ Not Medically Necessary ❑ Non-PPO Penalty ❑ Excluded/Not Covered ❑ Not Pre-certified/No Prior Authorization ❑ Other:

**COMPLETE THIS SECTION FOR AN APPEAL FOR DENIED BENEFITS**

Claim number(s): Service "from/to" date(s):

Provider:

On page two of this form, state the reasons why your appeal should be granted, including a summary of the facts. Please cite any Plan provisions that support your reasons, attach all supporting documentation for your appeal and sign below.

Signature of Employee: Date:

**COMPLETE THIS SECTION FOR AN APPEAL FOR A DENIED PRE-CERTIFICATION OR PRIOR AUTHORIZATION**

Denied by: ❑ URM ❑ Trust Administrator ❑ PBM

Appeal type: ❑ Inpatient Hospital ❑ Surgery ❑ Lab/X-ray/Scan ❑ Mental Health Therapy ❑ Other Therapy, specify: ❑ Travel ❑ Dental ❑ Other:

Date of appeal: To URM: To PBM: Date of denial:

On page two of this form, state the reasons why your appeal should be granted, including a summary of the facts. Please cite Plan provisions that justify your reasons, attach all supporting documentation for your appeal and sign below.

Signature of Employee: Date:

Use this page to state the reasons why your appeal should be granted, including a summary of the facts. Please cite any Plan provisions that support your reasons and attach all supporting documentation for your appeal.

The deadline for submitting appeals is 180 days from the date of the denial.

Employee name: Patient name: