# MEDICAL, DENTAL OR PRESCRIPTION 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

Use this form to submit an appeal for denied benefits, a denied pre-certification or a denied prior authorization. Appeals for a denied pre-certification should be submitted to the Utilization Review Manager (URM) or for the denial of a prescription drug authorization to the Pharmacy Benefits Manager (PBM), before submission to the ASEA Health Benefits Trust. 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 and fax the form and your attachments to the ASEA Health Trust Administrator at the above number or mail your appeal to the address shown.

**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: