Craig A. Fahey
Attorney at Law

Appeals Form

Name:_____ Date of Birth:_____

SSN:_____ Phone:_____

Address:_____

Your Medical History

Medical Provider: MD / Hospital / Lab	Address Phone Fax	Dates of Treatment	Medical Condition Treated

After your claim was denied, were you treated for any NEW diagnoses: yes / no

If "yes" please explain below.

New Diagnosis	Treating Physician	Dates of Treatment From	To

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Current Medications

NAME OF MEDICATION	DOSAGE (MG/CM)	FREQUENCY TAKEN	PRESCRIBING DOCTOR'S NAME	PURPOSE AND SIDE EFFECTS