

Address:\_\_\_\_\_

## Appeals Form

MEDICAL PROVIDER: MD / HOSPITAL / LAB	PHONE	TREATMENT	CONDITION			
	FAX		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				

YOUR MEDICAL HISTORY

Name:\_\_\_\_\_ Date of Birth:\_\_\_\_

PHONE:



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## **CURRENT MEDICATIONS**

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