NOTICE OF APPEAL

Before filing this appeal, please contact the MedBen Customer Service Department, unless you have already done so. They may be able to provide you with additional information or resolve your complaint for you.

Full Name of Employee/Primary Insured *(Participant)*: _____

Insured (Participant) Social Security/Identification Number:_____

Individual whose Claim/Precertification is subject of Appeal *(Claimant)*: _____

Relationship of Claimant to Participant:_____**Is Claimant a Minor?** *Yes* ☐ No ☐

MedBen Group Number:_____ **Name of Employer**: _____

Name of Individual filing Appeal: _____

Relationship to Claimant: _____

Have the requested Services/Supplies which are the Subject of this Appeal already been provided to the Claimant? Yes ☐ No ☐ **When were such services or supplies provided, or when are they scheduled to be provided?***:* _____

Appeal Involves:

- ☐ Complete or partial denial of request for precertification
- ☐ Complete or partial denial of claim
- ☐ Eligibility Issue
- ☐ Other: _____

Briefly describe the health plan determination which is the basis of the appeal (*attach additional sheets, if necessary)*: _____

_____

_____

_____

Claim Number(s) Related to Appeal: *(see Explanation of Benefits)*_____

_____

Why do you believe that this determination was incorrect? *(attach additional sheets, if necessary)* _____

_____

_____

_____

List a chronology of all contacts made with MedBen or representatives of your health plan regarding this claim/precertification, including how the contact was made, date, who made the contact, the MedBen representative involved and the result of the contact *(attach additional sheets, if necessary)*: ____

_____

_____

_____

_____

AUTHORIZATION(S): ***If appeal is filed by the Claimant or Parent/Legal Guardian of a Minor Child, Section ❶ must be completed. If the Individual filing Appeal is other than Claimant or Parent/Legal Guardian of a Minor Child, Section ❷ must be completed and the attached "Designation of Authorized Representative must also be completed.***

❶ I certify that the information provided above is correct, to the best of my knowledge and belief.

I acknowledge that this certification also applies to anyone I've designated as my representative for this appeal.

I authorize any medical providers or other parties to release to MedBen, any and all medical records and information regarding my medical condition, diagnosis, treatment, prognosis, care, and/or hospitalization which is relevant to this appeal. Such information includes case management notes, psychotherapy notes, medical utilization notes, clinical patient data, medical opinions and evaluations, including information from the health care providers which has been accumulated by the medical providers during the care of the undersigned. The information released pursuant to this authorization is to be used for the purpose of reviewing and deciding issues which are relevant to the subject of this appeal.

I understand that if I fail to provide this authorization, MedBen will be unable to process my appeal. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officerof my health plan at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen's receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law.

This authorization is effective on the date signed and shall remain in effect for the duration of the undersigned's appeal under the MedBen insured plan or the employer's employee health benefit plan. A photocopy of this authorization shall be as valid as the original. The undersigned, and any individual authorized by law to act on behalf of the undersigned, shall have a right to receive a copy of this authorization.

I also understand that information relative to this appeal may be provided to the Plan Administrator of my Health Plan, which may be the employer sponsoring the plan, if my Health Plan is self-funded. This information may also be disclosed, at such Plan Administrator's discretion, to other individuals who are assisting the Plan Administrator in making any necessary determinations, such as any broker or agent who is employed by the Plan Administrator to assist in the administration of the Plan.

Dated:_____ **Signed:**_____

Claimant
(or Parent/Legal Guardian of Claimant, if a Minor)

Email Address:_____

❷ I certify that I am properly authorized to file the above appeal, and that the information provided above is correct, to the best of my knowledge and belief.

Dated:_____ **Signed:**_____

Individual Filing Appeal (If Other Than Claimant)

Email Address:_____

Return completed form to:
Appeals Committee
c/o Medical Benefits Administrators, Inc.
P.O. Box 1099
Newark, Ohio 43058-1099
Fax: 740-522-5002
Email: memberclaimsfax@medben.com

DESIGNATION OF AUTHORIZED REPRESENTATIVE FOR APPEAL

I hereby authorize _____ to file an appeal on my behalf regarding _____ and to act as my representative in all matters regarding this appeal. I request that MedBen *(Medical Benefits Mutual Life Insurance Co., Medical Benefits Administrators, Inc. or VisionPlus of America, Inc.)* direct all correspondence regarding this appeal to this individual at the following **email address and fax number**: _____

_____

Pursuant to this authorization, I request that MedBen release any information to my designated representative, any and all information which is relevant to this appeal, including, but not limited to, medical records and information regarding the undersigned's medical condition, diagnosis, treatment, prognosis, care, and/or hospitalization. Such information may include case management notes, psychotherapy notes, medical utilization notes, clinical patient data, medical opinions and evaluations, and information from the undersigned's health care providers which has been accumulated by MedBen on its own behalf as an insurer, or as third party administrator for my employer sponsored self-funded plan, as well as claims, claims payment, and eligibility information. The undersigned understands that upon signing and returning this document, such information and records will be released by MedBen, to said authorized representative at various times, as requested by said authorized representative.

I understand that information disclosed by MedBen to any individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals, and will no longer be protected by this authorization. I understand that if I fail to provide this authorization, MedBen will be unable to process my appeal. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer of my health plan. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen's receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law.

The undersigned hereby agrees to indemnify and hold MedBen harmless from any and all claims, lawsuits, settlements, judgments, costs, penalties and expenses, including attorney's fees, for releasing such information and records pursuant to this document.

I further authorize any medical providers or other parties to release to MedBen, any and all medical records and information regarding my medical condition, diagnosis, treatment, prognosis, care, and/or hospitalization which is relevant to this appeal. Such information includes case management notes, medical utilization notes, clinical patient data, medical opinions and evaluations, including information from the health care providers which has been accumulated by the medical providers during the care of the undersigned. The information released pursuant to this authorization is to be used for the purpose of reviewing and deciding issues which are relevant to the subject of the appeal filed on my behalf on _____.

This authorization is effective on the date signed and shall remain in effect for the duration of this appeal under the MedBen insured plan or the employer's employee health benefit plan. A photocopy of this authorization shall be as valid as the original. The undersigned, and any individual authorized by law to act on behalf of the undersigned, shall have a right to receive a copy of this authorization.

I understand that this authorization does not cover any post appeal actions filed on my behalf, including, but not limited to, insurance department or other governmental agency complaints, court actions or other post appeal actions which are allowed under state or federal law. I further understand that if this individual is to continue to act on my behalf in these post appeal proceeding, another appropriate authorization may be requested.

I also understand that information relative to this appeal may be provided to the Plan Administrator of my Health Plan, which may be the employer sponsoring the plan, if my Health Plan is self-funded. This information may also be disclosed, at such Plan Administrator's discretion, to other individuals who are assisting the Plan Administrator in making any necessary determinations, such as any broker or agent who is employed by the Plan Administrator to assist in the administration of the Plan.

DATED this _____ day of _____, 20___.

_____

Claimant