

Address:_____

MEDICAL PROVIDER:

Appeals Form

MEDICAL

MD / HOSPITAL / LAB	PHONE FAX	TREATMENT	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			

Name:_____ Date of Birth:_____

SSN:_____ PHONE:_____

ADDRESS

YOUR MEDICAL HISTORY

DATES OF



Appeals Form

CURRENT MEDICATIONS

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