



# 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

