

REQUEST FOR REVIEW OF AN ADVERSE BENEFIT DETERMINATION

Please complete (in printing) this adverse benefit determination appeal form and return to: Attention: Appeals Committee, NECA-IBEW Welfare Trust Fund, 2120 Hubbard Avenue, Decatur, IL 62526-2871. You have up to but not more than 180 calendar days after receipt of the written denial notice to decide whether you wish to file an appeal.

Employee's name: _____

Employee's social security number: _____

Employee's address: _____

Street and/or P. O. number

City

State

Zip

Employee's telephone number: _____

Home

(Area Code + Number)

Work

Patient's name: _____

Patient's social security number: _____

Patient's mailing address: _____

(if different than employee's)

Street and/or P. O. number

City

State

Zip

Patient's Telephone Number: _____

(if different than employee)

Home

(Area Code + Number)

Work

Patient's E-mail address: _____

(ONLY IF YOU CONSENT TO BEING CONTACTED VIA E-MAIL)

Date(s) of Service of denied Claim(s): _____

Claim number(s) of denied Claim(s): _____

Signature of Patient or Patient's Representative

Date

Persons to whom disclosure will be made:

5 Union and 5 Employer Trustees of NECA-IBEW Appeals Committee
Fund Administrator and/or Assistant Fund Administrator
Fund Claims Manager
Fund Legal Counsel
Fund Consultant

Section B: NECA-IBEW has requested this authorization

- a. The purpose of the use or disclosure is to discuss your appeal of an adverse benefit determination.
- b. NECA-IBEW will not receive financial or in-kind compensation in exchange for disclosing the health information described above.

Section C: Must be completed by the patient or the patient's representative

The patient or the patient's representative must read and initial the following statements:

1. I understand that the payment for my health care will not be affected if I do not sign this form. Initials: _____
2. I understand that I may see and copy the information described on this form if I ask for it and that I receive a copy of this form after I sign it. Initials: _____
3. I understand that I may revoke this authorization at any time by notifying NECA-IBEW in writing, but if I do it won't have any affect on any actions taken before NECA-IBEW received the revocation. Initials: _____
4. I understand I may terminate this authorization on a specific date. This authorization will expire on ____/____/____ Initials: _____
5. I understand that information used by, or disclosed to, any entity other than a health plan or health care provider may no longer be protected by the federal privacy law. Initials: _____

Date: ____/____/____

Signature of patient or patient's representative

Printed name of patient's representative: _____

Relationship to the patient: _____

FORM MUST BE COMPLETED BEFORE SIGNING!

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION