Participant Appeal Form

Participant name: ____ Date: ____________________

Name of person filing appeal: ____

Relationship to Participant:

☐ Self ☐ Family ☐ Caregiver ☐ Other ______________________________

Participant has following request: ____

____

Previously what had been done to resolve: ____

____

Tell us why this did not work for you? ____

____

What can we provide that is ***Medically Necessary*** to remedy this situation? _________________

____

____

Office Use Only: Third Party Review

☐ *Approved, Date: _________________ Time: _________________*

☐ *Denied, Date: __________________ Time: _________________*

Reason Denied/Approved: ____

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Signature: ____ Date: ____________________