

**Comprehensive Care Services
APPEAL FORM**

Inquirer Name _____

Daytime Phone Number _____

Address _____

Relationship to subscriber:

self spouse

child other _____

Subscriber Name _____

Group Number _____

Identification Number _____

Patient Name _____

What is your appeal/concern regarding? _____

Claim numbers in question:

Date of service:

Please provide narrative description of the appeal or problem in the space provided or attach a separate sheet (include names and dates when possible):

What would you like from our review? _____

I hereby authorize you to forward a copy of this information to the provider, if necessary, to conduct our internal review of the situation.

Signature _____ Date _____

APPEAL PROCEDURES

For specific details on the Appeal Process, please refer to your summary plan description.

You or your designated representative may appeal a denial or partial denial of your claim by following our appeal procedure. If you wish to file an appeal, please follow these steps:

- A. You may submit any documents, records, or other information that relates to your claim for benefits. You may file a formal written appeal by returning the appeal form and any supporting documentation. Notice of the resolution will be provided in writing and mailed to you within 30 days after the formal appeal is filed. If a decision cannot be made within 30 days due to circumstances outside of our control, we may take an additional 14 days to notify you, provided we notify you in advance of the extension and the reasons for the delay.
- B. **If your group health plan is subject to ERISA**, once you have completed the formal appeal process, you have the right to file suit in Federal Court under Section 520(a) of ERISA.

Please send completed form to:

Comprehensive Care Services
P.O. Box 64668
St. Paul, MN 55164

Customer Service
1-800-365-2735
651-662-5940