REQUEST FOR REVIEW OF BENEFIT DENIAL

Important Notice: This request for review must be received by the Plan within 180 days of the date of the Notice of Benefit Denial or Adverse Determination. Failure to file a timely appeal will bar you from any further review of this benefit denial under these procedures or in a court of law. Be certain to keep copies of this form, your denial notice and all documents and correspondence related to this claim.

Please complete this form with the requested information.

Person Filing this Appeal: (check one) ☐ Employee, ☐ Patient, ☐ Authorized Representative (If Authorized Representative, the claimant must complete an Appointment of Authorized Representative.

Employee Name	Member ID
Address	Claimant Name
City	Group Name
State	Group Number
Zip Code	Phone Number

Authorized Representative	
Address	
City	
State	Relationship
Zip Code	Phone Number

Date of Notice of Benefit Denial	Claim/Case Number
Provider Name	Date of Service

Describe the reasons why this benefit denial should be changed on appeal. (Attach additional pages and relevant documentation, as necessary.)

Signature: _____ Date: _____

SUBMIT THIS REQUEST FORM WITH ALL SUPPORTING DOCUMENTATION BY MAIL TO:

IMPORTANT: If this is an urgent care appeal, as defined by law, you may submit the information contained in this Request for Review Benefit Denial form by contacting

submit.t13@90degreebenefits.com
Fax: 1-412-202-5763 | Mailing Address: Manor Oak Two, Suite 605, 1910 Cochran Road, Pittsburgh, PA 15220