ORANGE - ULSTER
SCHOOL DISTRICTS
HEALTH PLAN

DATE _____

APPEALS PROCEDURE FORM

(To be completed by the plan member)

School District: _____

School District Representative: _____

Employee Name: _____ Social Security # _____

Patient Name: _____

List the claim #'s and attach copies of Explanation of Benefits (EOB) for each claim being appealed.

CLAIM #	DATE OF SERVICE	PROVIDER

List the section and page of the Plan Booklet that applies to this appeal.

_____

Write a clear and concise narrative describing the appeal, use additional paper if necessary. Attach all relevant documentation.

_____
_____
_____
_____
_____
_____
_____

Plan Member Signature: _____

11/96