Final Appeal Request

Please provide the following information for the primary member:

Today's Date	Member's ID Number	Member's Group Number (optional)
Member's First Name	Member's Last Name	Member's Birthdate (MM/DD/YY)

Please provide the below information for the person you are submitting the request for:

First Name	Last Name	Birthdate (MM/DD/YY)
Relationship to person requesting the appeal: ☐ Self ☐ Spouse ☐ Child Other_____ **Note:** If your selection is spouse, child (18 years of age or older) or other, please complete and include the Authorized Representative Form with your request.		
Please advise if the appeal is related to ☐ Pre-Service ☐ Post Service		

To help us review and respond to your request, please provide the following information.

Claim Number	Date of Service
CPT/HCPC/Service being disputed	
Explanation of your request (Please use additional pages if necessary)	

Insurance Commission Decision:

Meeting Date:
Appeal Decision:

Note: To help us review your request please provide the bills and /or correspondence for these services and any other helpful information.

Please return to:
Passaic County Department of Human Resources
401 Grand St
Paterson, NJ 07505

FINAL HEALTH APPEAL- AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Group Health Plan: [Plan Name]
Claimant's Alternate ID: [#]
MRV #

Appointment of Authorized Representative for Final Appeal

I, _____, hereby appoint _____
([Name of Claimant]) (Authorized Representative)

to act on my behalf in connection with the appeal for claim(s) **for date(s) of service** _ for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to file appeals on my behalf in connection with the appeal for claim(s) for date(s) of service specified above for coverage or benefits. I authorize my representative to receive all information that is provided to me and to act for me (or my dependent, if named above as the patient), in providing any information to the Plan that relates to the appeal for claim(s) for date(s) of service specified above for coverage or benefits under the Plan.

IMPORTANT: All information and notifications from the Plan related to the appeal will be directed to the authorized representative appointed through this form and not to you, unless you direct otherwise by checking below:

Distribute to my authorized representative and me: All information and notifications should be distributed to my authorized representative and me.

_____ _____
Claimant Signature **Date**

Please return to:
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401 Grand St
Paterson, NJ 07505