# Member Appeal Form

Please fully complete the form and indicate the reason(s) why you believe the claim payment or determination is incorrect and should be changed. You may attach a written statement or additional documentation to back up your request. Please include a copy of any bill(s) you may have received from your provider, if applicable. All appeals must be submitted within 180 days from the original claim determination (or any other applicable timeframe that may be identified in the plan document). Judi Health will respond to your appeal within the applicable timeframe required by law.

## Claim Information

| | |
|---|---|
| Subscriber Name: | Subscriber ID Number: |
| Employer Name: | Group Number: |
| Patient Name: | Date of Birth: |
| Date(s) of Service: | Procedure/Type of Service: |
| Claim Number(s): | |

## Health Care Provider Information

| | |
|---|---|
| Practitioner/Facility Name: | |
| Address: | City, State, Zip: |
| Telephone: | Fax: |

## Appeal Description

Please describe in detail your reason(s) for appeal:

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|---|
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Please note that while we implement reasonable safeguards to protect your protected health information (PHI) sent through email, there is some risk your PHI could be read or otherwise accessed while in transit. If you prefer, you may instead mail or fax your information. Completed forms can be sent to:
Email: appeals@judihealth.com
Fax: 833-FAX-JHLT (329-5458)
Mail: Judi Health Attn: Appeals Dept 9450 SW Gemini Dr., #87234 Beaverton, OR 97008

Signature:_____ Date: _____

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