Request for Review of Benefit Denial

Please complete this form with the requested information.

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.

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

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

Authorized Representative:	Relationship:
Address:	Phone Number:
City:	
State:	
Zip Code:	

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.)

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Signature_____ Date_____

Submit this Request Form with all supporting documentation by mail to:

EBSO, Inc.
Attn: Appeals Department
P.O. Box 928
Findlay, OH 45839

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 EBSO, Inc. at 1-800-558-7798 or by fax at 1-419-423-5834.

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