ACTIVA BENEFIT SERVICES
APPEAL FORM

Persons enrolled in _____ may use this form to appeal to Activa Benefit Services regarding a denied claim. **To be considered a valid appeal, this form must be received within 180 days of the final adverse decision of the plan.**

Your Name _____ Member I.D.# _____
Name of Enrolled Employee _____
Address _____
City _____ State _____ Zip _____
Home Phone ( ) _____ Business Phone ( ) _____
Patient Name _____ Date of Service _____

Name of Physician, Hospital, or
Other Health Care Provider _____

CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR THE APPEAL:

___ Disagree with the amount paid on a claim or with the amount of member copayment
___ Believe the claim was for a covered service and should not be denied for payment
___ Believe a service was medically necessary, though denied as not medically necessary
___ Eligibility issue. Please describe _____
_____
_____
___ Other. Please describe _____
_____
_____
_____

PLEASE ATTACH DOCUMENTS RELEVANT TO YOUR APPEAL. For example: Explanations of Claims Processed, other correspondence from plan, letter from your physician, bill from your health care provider. Are documents attached? ___ Yes ___ No

Appeals should be addressed as follows:

ATTN: APPEALS DEPARTMENT
ACTIVA BENEFIT SERVICES
660 ADA DRIVE SE, SUITE 201
ADA, MI 49301

Please mark the envelope Confidential-Appeal Enclosed

What specific remedy do you seek in filing this appeal?_____
_____
_____
_____
_____

SIGNATURE _____ DATE _____