INFORMATION REQUEST FORM – APPEALS

About You

Plan ID Number: _____

Your Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Information Requested

Please check the plan under which you are requesting records:

☐ GEHA Health Plan (FEHBP) ☐ CONNECTION Vision Plan ☐ Other)_____

☐ Connection Dental *Plus* Plan ☐ GEHA Connection Dental Federal Plan (FEDVIP Plan)

Please provide a detailed description, including claim number(s) and/or dates of service for which you are requesting records:

_____

_____

_____

_____

I request a copy of records relevant to the benefit determination made by GEHA. I understand that this request for records is not considered an appeal as described in the Disputed Claims section of my plan brochure, or other applicable plan document.

Format: ☐ Paper copy ☐ Electronic copy

Information to be released to: ☐ Self

☐ Other (Must be designated as Authorized Representative. Please fill in contact information below. If necessary, please also include Authorized Representative form.)

Mail to Name: _____

Mail to Address: _____

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____

(i.e., parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

ATTN: Appeals
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816-257-3283