GEHA®

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MEDICAL APPEAL FORM

If you would like GEHA to reconsider our initial decision on your benefit claim, please complete this appeal form. You must write to us within 6 months of the date of our decision.

You can mail, fax or email your request to GEHA:

- Mail your request to GEHA, PO Box 21542, Eagan, MN 55121;
- Fax your request to the Appeals Department at 816.257.3256; or
- Email your request to GEHAappeals@geha.com

Patient name: _____

Plan ID number: _____

Claim number(s): _____

Your name: _____

Your status: ☐ Enrollee ☐ Patient

☐ Legal representative, e.g., Power of Attorney, Guardian, Executor

☐ Authorized representative (The patient or parent of a minor child must complete and sign the second page of this form.)

If a legal representative, explain your relationship to the patient, and attach a copy of the legal document:

_____

Your mailing address: _____ (Street address) (City) (State) (ZIP code)		
Your phone number: ( ) -	Your email address:	Prefer response by: ☐ Letter ☐ Email

Please explain why you believe our initial decision was wrong, based on specific benefit provisions in your plan brochure:

Attach additional sheets, if needed. Supporting documents may be necessary for review, such as an operative report for a review of surgery charges. Please send copies of documents that support your appeal, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms. The review may be delayed if supporting documents must be requested by GEHA.

I confirm that the above information is correct.

Signature: _____ Date: _____

Relationship to patient: _____
(e.g., parent, legal guardian, medical power of attorney, appeals authorized representative)

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

GEHA Appeals Department
P.O. Box 21542 | Eagan, MN 55121
Fax 816.257.3256 | Email GEHAappeals@geha.com

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AUTHORIZED REPRESENTATIVE DESIGNATION FOR BENEFIT APPEAL

This form is for enrollees and dependents covered by the GEHA Health and Connection Dental *Plus*® plans. Please place a check mark in front of each plan you want this Authorized Representative designation to be applied. (NOTE: At least one line MUST be checked for this form to be valid.)

☐ GEHA health plan (includes Connection Vision plan)

☐ Connection Dental *Plus*® plan (includes Connection Vision plan)

Member name: _____ **GEHA ID number:** _____

Patient name: _____ **Date of birth:** _____

Designated Authorized Representative name:
(Referred to as the "Representative." A contact person must be provided if this is an entity/organization.)

Representative complete address: _____

_____ **Representative phone number:** _____

Claim number (if filed), Provider name, description of service, and date(s) of service (unless proposed):

_____

I name the above person to act as my authorized representative in requesting information from GEHA regarding the above-noted provider, service or proposed service.

The purpose is specifically for requests in regard to an adverse benefit determination and/or appeal only as outlined in the Affordable Care Act (ACA).

IMPORTANT: Your signature below means that you understand and agree to the following:

- GEHA may disclose Protected Health Information (PHI) to the Representative, including, but not limited to history, physical, physician notes, nurses' notes, other treating providers, diagnosis, procedures, etc.
- The PHI disclosed to the Representative may include PHI you may consider to be sensitive information. (Please note there is no limit to the information the Authorized Representative may request in regard to the provider and name/dates of services documented above).
- If you sign this form, you may revoke the authorization at any time by notifying GEHA in writing at the address below. Revoking this authorization will not have any effect on actions GEHA took before receiving the revocation.
- GEHA will not condition treatment, payment, enrollment or eligibility for benefits based on this form. Your signature is required to process the request for appeal, plan information, and/or PHI initiated by the Representative.
- Information disclosed as based on this form may be further disclosed by the Representative without your authorization and may no longer be protected by federal or state privacy regulations.
- This authorization is only valid for the duration of the appeal and will expire when completed.

Please accept this appeal and any requests for PHI related to the appeal from my authorized representative on my behalf.

Date: _____

Patient or Legal Representative's signature: _____

Signer's relationship to patient: _____ **Signer's phone number:** _____
(e.g., self, 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.

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