# Member Appeal Request Form

Please complete all requested information and submit the complete form to the address below.

| Subscriber Name: | |
|---|---|
| Employer/Group ID: | |
| Subscriber ID number: | |
| Patient Name: | |
| Claims Number: | Dates of Service: |
| Provider or Facility Name: | |

Please provide the details for the Appeals Request in the box below: Example: If your claims was denied for medical necessity, you will want to submit your provider's medical records.

Signature___________________________ Date:__________________

**Return form to the HealthEZ Appeals Department at Service@HealthEZ.com or fax to 952-255-6380**

If you need assistance completing this form please contact 1-800-948-9450