



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