MEDICAL MUTUAL OF OHIO

MEMBER APPEAL FORM

CONSUMERS LIFE INSURANCE COMPANY
A MEDICAL MUTUAL OF OHIO Company

Date of Request _____

PATIENT INFORMATION

NAME:	MEMBER ID #:	DOB:

NAME OF REPRESENTATIVE PURSUING APPEAL, IF DIFFERENT FROM ABOVE:

RELATIONSHIP TO PATIENT:

STREET ADDRESS:

CITY:	STATE:	ZIP CODE:

DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:

TYPE OF DENIAL: Denied Claim for Service Already Provided ☐ Denied Service Not Yet Received ☐

TYPE OF REQUEST

(Please check one)

- ☐ Benefit / Coverage Issue
- ☐ Dental Service
- ☐ Medical necessity denial – postservice
- ☐ Medical necessity denial – preservice
- ☐ Prescription Drug
- ☐ Vision Service
- ☐ Other

CLAIM/CASE NUMBER INFORMATION

Date of Service:	Claim #:	Case # from denial letter:
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REASON FOR APPEAL

Explain what decision you are appealing (Attach additional sheets of paper if needed):

Make sure to attach everything that shows why you believe your plan should cover this claim or authorize a service including: Medical records and supporting documentation (letter from your doctor, office records, surgical reports, photos, lab reports, x-ray reports, etc.).

Mail to: Medical Mutual
Member Appeal Unit
P.O. Box 94580
Cleveland, Ohio 44101-4580

or FAX 216/687-7990

L6854 R12/2006