

Date	
Employer	
Employee Name	
Employee Health Care ID (HCID) #	
Patient Name	
Health Care Provider	
Date of Service	
Claim Number	

Reason Provided for Denial of Claim  
(Check One)

<input type="checkbox"/>	Services received were investigational and/or experimental in nature	<input type="checkbox"/>	Provider(s) was out-of-network
		<input type="checkbox"/>	Treatment not approved by the FDA
<input type="checkbox"/>	The claim was not submitted on time (i.e., within the timely filing period)	<input type="checkbox"/>	Services received were not medically necessary
		<input type="checkbox"/>	The number of inpatient days was not authorized
<input type="checkbox"/>	There is no additional allowance for an incidental procedure performed at the same time as the primary procedure.	<input type="checkbox"/>	Failed to receive pre-authorization
		<input type="checkbox"/>	Services were not covered under the plan
		<input type="checkbox"/>	Treatment was not within the standard of care
<input type="checkbox"/>	The patient was not eligible for benefits at the time services were received	<input type="checkbox"/>	Services received were for an excluded, pre-existing condition
<input type="checkbox"/>	Other: _____		

Reason(s) for Appeal

The claim is being appealed for the following reason(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Supporting Material

Additional Documents Enclosed:  Yes; number of pages in addition to this page: \_\_\_\_\_  No

Documents Enclosed:  Medical Records  Physician's Statement  Bill/Billing Statement

Other: \_\_\_\_\_

Verification

I hereby verify that the above information is true, complete and accurate to the best of my knowledge. I understand that Delta Health Systems is the Third Party Administrator for the Health Plan and that services provided by Delta are strictly limited by the provisions contained in the Plan Booklet; the Employer determines plan exclusions and limitations.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send this form, and any Supporting Material, to Delta health Systems: P O Box 1931, Stockton CA 95201.  
If you have any questions, please call 1-800-422-6099.