ebms
Improving Lives

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Appeal Form

Member Information			
Member Name		Member ID	
Patient Name		Group Number	
Address	City	State	Zip code
Phone number		Email address	

Your status:

☐Enrollee/Patient ☐Provider

☐Legal representative, e.g., Power of Attorney, Legal Guardian, Executor or Personal Representative of the Estate (if you are any of these, please attach proof of such)

☐Authorized representative (If you are appealing for someone other than yourself, such as your spouse, a child (18 years of age or older) or another adult age 18 or over, please complete the: 1) Authorized Representative Form, or a 2) HIPAA Authorization to Release PHI. You do not need to complete both forms.

The HIPAA Authorization to Release PHI and the Authorized Representative Form can be found at ebms.com under Forms.

Claim Information			
Document Number	Date of Service	Document Number	Date of Service
Document Number	Date of Service	Document Number	Date of Service

☐First Level Appeal ☐Second Level Appeal ☐Pre-Service Appeal

Appeal Reason

Please describe in your own words, why you disagree with the determination on the claim(s):

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 EBMS.

☐Please provide copies of information relevant to the claim with the appeal response.

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)