Your Future — Our Focus

Mid-America Carpenters Regional Council
HEALTH BENEFIT FUNDS

(312) 787-9455, option 3 for Actives, option 4 for Retirees • carpenterbenefits.org

All sections are required – avoid delay in processing of your appeal by completing this form in its entirety, including your dated signature. Print **clearly** using **black or blue ink**.

APPEAL FORM: HEALTH BENEFITS

REQUIREMENTS TO FILE AN APPEAL. Both requirements must be met to file an appeal.

1. **Timeliness.** Appeals must be filed **no more than 180 days** after receipt of an adverse benefit determination.
2. **Right to Appeal.**
   - Appellant must be either a participant, the patient, the parent/guardian of the patient, or an Authorized Personal Representative (*submission of completed and signed Authorized Personal Representative Designation Form is required*).
   - Only the following may be appealed:
     - Denial of Enrollment in or Eligibility for Health Benefits; or
     - Adverse Benefit Determinations/Denied Medical Claims (Active Plan Only*). Reduction or termination of a benefit, or denial, in whole or in part, for a claim for benefits by the Fund Office meaning that services have been rendered and the claim has been received and processed by the Fund Office.

The following cannot be appealed through this form and process:

- Pre-determinations of benefits. A verbal or written request to the Fund Office by a provider or participant to determine whether a certain procedure, prescription, or treatment is covered under the Plan.
- Claims administered by third-party vendors; appeal to the vendor directly as follows: **Dental Plan** = Delta Dental; **Vision Plan** = VSP; **Prescription Plan** = Express Scripts; or ***Retiree Medical Claims** = BCBSIL.

Appeal regarding (check one)**:** ☐ **Active Plan of Benefits** ☐ **Retiree Plan of Benefits**

SECTION 1: APPELLANT INFORMATION *Information for the individual filing this appeal.*

Appellant is: ☐ Participant/Carpenter ☐ Surviving Spouse ☐ Patient ☐ Authorized Personal Representative

Appellant Full Name _____ Last 4 digits of Social Security # _____

Mailing Address: Street, City, State, Zip Code _____

Mobile Phone # _____ Email Address _____

SECTION 2: PARTICIPANT/CARPENTER INFORMATION

☐ Check here if same as Section 1 and skip to Section 3.

Participant/Carpenter Full Name _____ Participant UID (see BCBSIL ID Card) _____

Mailing Address: Street, City, State, Zip Code _____

Mobile Phone # _____ Email Address _____

SECTION 3: APPEAL INFORMATION

Appeal regarding (check one)**:**

☐ **Denial of Enrollment in or Eligibility for Health Benefits**, *go to Section 4.*

☐ **ACTIVE PLAN ONLY: Adverse Benefit Determination (i.e., denied claim)**, *complete this section.*

Claim Number(s) *see Explanation of Benefits* | Date(s) of Service | Name of Provider(s)

Patient is: ☐ Participant/Carpenter ☐ Spouse ☐ Dependent Child

Patient Full Name | Date of Birth (MM/DD/YYYY)

Mailing Address: Street, City, State, Zip Code *(only need to complete not already provided in Sections 1 or 2 on page 1).*

SECTION 4: APPEAL STATEMENT

☐ **I have attached a statement which includes the following requirements:**

- **The decision** made by the Fund Office that you are appealing;
- **The reason(s)** you believe the Fund Office decision is not correct; and
- **Evidence, specific facts, and Plan provisions** that support/substantiate your appeal.

Write the participant last name and last 4 digits of their SSN on every page of your appeal statement.

SECTION 5: SIGNATURE

I declare that the information, statements, and documentation I have provided in regard to this appeal are true and complete to the best of my knowledge and belief. I understand that making false statements and/or furnishing false information will disqualify my case.

X _____ _____

Signature of Appellant | **Date**

Submit your completed, signed form and all supporting documentation/evidence via the method most convenient for you:

MAIL/DROP-OFF ▶ MACRC Benefit Fund Office, Attn: Health Benefit Appeals, 12 E Erie St, Chicago, IL 60611

EMAIL ▶ **Active Plan**: appeals@carpenterbenefits.org; **Retiree Plan**: retirement@carpenterbenefits.org

FAX ▶ **Active Plan**: (312) 951-1515; **Retiree Plan**: (312) 951-3986

What happens next? Within five (5) business days of the Fund Office receiving your appeal, you will be sent acknowledgement of receipt. Properly filed appeals will be reviewed at the next regularly scheduled Appeals Committee meeting (held at least once per quarter).