AmericanAirlines®

EMPLOYEE BENEFIT COMMITTEE

APPLICATION FOR SECOND LEVEL APPEAL: PRESCRIPTION DRUG COVERAGE

THIS APPLICATION FOR SECOND LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING YOUR PRESCRIPTION DRUG COVERAGE (MEDICAL NECESSITY OF MEDICATIONS, PRIOR AUTHORIZATION, EXCLUDED MEDICATIONS, ATTEMPTING TO REFILL MEDICATIONS TOO EARLY, ETC.)

IMPORTANT NOTICE:

YOU MUST COMPLETE THIS FORM AND PROVIDE ALL REQUESTED INFORMATION; OTHERWISE, YOUR APPEAL CANNOT BE ACCEPTED FOR REVIEW BY THE EBC.

In order for the EBC to carefully review the facts and give every consideration to your issue, you must include all of the information requested below. Failure to provide all pertinent documentation may affect the outcome of this review. It is essential that you keep copies of all documentation you submit in support of your Second Level Appeal. The information you submit is provided at your own expense. The records submitted will be retained by the EBC. You must file this Second Level Appeal within 180 days of the date you receive notice of First Level Appeal determination from the Prescription Benefit Administrator or Claim Processor; otherwise, your right to further appeal is waived.

Your appeal must include the following:

- Complete, date, and sign this APPLICATION FOR SECOND LEVEL APPEAL (both employee and patient, other than a minor, must sign this Application)
- Attach a copy of the Prescription Benefit Administrator's or Claim Processor's First Level Appeal determination letter
- Explain, in detail, why you believe your issue in question should be approved by the EBC
- Include all information and documents that you believe support your appeal
- Attach all Explanation of Benefit Statements (EOBs) you have received relating to this issue
- Include copies of all correspondence that you sent to or you received from the Prescription Benefit Administrator or Claim Processor
- Include any published literature and/or documentation, if applicable, related to the medication at issue
- Include copies of all your prescription receipts for the claim at issue
- Include documentation of any telephone conversations you had with the Prescription Benefit Administrator
- If your issue of appeal involves medical necessity for your medication, prior authorization for your medication, or if your medication is being used for purposes other than those approved by the US Food and Drug Administration, please include complete clinical records from the prescribing physician and from any other physicians with whom you've consulted regarding this particular medication
- If you experienced any extenuating circumstances that you believe have a bearing on your appeal, include complete and specific details of such circumstances, and provide documentation to support the existence of such circumstances, and how they affected your case
- Other_____

Your failure to provide all pertinent documents may affect the outcome of your appeal review.

THIS WILL BE YOUR ***FINAL*** ADMINISTRATIVE REVIEW; THEREFORE, INCLUDE ALL FACTS AND CIRCUMSTANCES THAT YOU WANT THE EBC TO CONSIDER WHEN IT REVIEWS YOUR SECOND LEVEL APPEAL. AFTER THE EBC RENDERS A DECISION ON YOUR APPEAL, ADDITIONAL OR NEW INFORMATION WILL ***NOT*** BE CONSIDERED. THEREFORE, IT IS IMPERATIVE THAT YOU INCLUDE ANY AND ALL PERTINENT INFORMATION WHEN YOUR SECOND LEVEL APPEAL IS SUBMITTED.

EMPLOYEE'S SECOND LEVEL APPEAL:

The benefit(s) to which I believe I am entitled is/are as follows (describe the type of benefit and the circumstances involving your case, being as specific as you can). Please refer to the specific Plan provision from your **Employee Benefits Guide**, which you believe entitles you to the benefit(s) you are claiming (attach additional pages if needed):

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TOTAL AMOUNT OF APPEAL (IF KNOWN) $_____

By signing this form, I attest to the validity of all information I have provided, and authorize the release of all clinical records and/or information pertinent to the evaluation of my appeal to the Prescription Benefit Administrator, the Claim Processor, and the EBC at American Airlines, Inc., and its agents, including any health care professional selected by the EBC to assist with the appeal review. American Airlines, Inc. is the sponsor and administrator for the group health and welfare benefit plans.

PLEASE PRINT, SIGN, AND DATE THE FOLLOWING:

EE Name:	**Benefit ID#:**
EE#:	**EE Signature:**
SS#:	**Patient Signature:**
Address:	**Date:**
Address:	**Home Phone:**
City:	**Work Phone:**
State:	**Cell Phone:**
Zip:	**Email:**

MAIL (or use express delivery) COMPLETED FORM AND SUPPORTING MATERIALS TO:

FOR USPS REGULAR MAIL DELIVERY	FOR EXPRESS DELIVERY
Employee Benefit Committee	**Employee Benefit Committee**
American Airlines, Inc.	**American Airlines, Inc.**
PO BOX 619616 MD #5134-HDQ1	**4333 Amon Carter Blvd. MD #5134-HDQ1**
DFW Airport, TX 75261-9616	**Fort Worth, TX 76155**
817-967-1412	**817-967-1412**