American Airlines

APPLICATION FOR FIRST LEVEL APPEAL: REHABILITATIVE SERVICES

THIS APPLICATION FOR FIRST LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING CONTINUING REPETITIVE TREATMENT AND REHABILITATIVE SERVICES (e.g., CHIROPRACTIC CARE, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, ACUPUNCTURE THERAPY, PSYCHOTHERAPY, ETC.)

In order for the Network/Claim Administrator or Claim Processor 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 First Level Appeal, as this documentation will be required if you choose to file a Second Level Appeal with the Employee Benefits Committee (EBC) at American Airlines, Inc. The information you submit is provided at your own expense. The records submitted will be retained by the Network/Claim Administrator. You must file this First Level Appeal within 180 days of the date you receive notice of the adverse benefit determination from the Network/Claim Administrator; otherwise, your right to both levels of appeal is waived.

Your appeal must include the following:

- Completed APPLICATION FOR FIRST LEVEL APPEAL (employee and the patient, other than a minor, must complete and sign this Application)
- Attach copies of all Explanation of Benefit Statements (EOBs) and all correspondence relating to this issue.
- Attach copies of the treating physician's orders for the therapy and/or treatment and clinical records for all evaluation and treatment rendered to the patient.
- Attach copies of the initial therapy evaluation (this should include the pre-treatment level of function, initial goals and treatment plan, modalities/exercises planned, etc).
- Attach copies of all periodic evaluations from the physicians and therapists
- Include copies of the daily treatment notes, which include the subjective/objective assessment and plan (frequently referred to as S.O.A.P. notes), for all prior and current visits.
- Include copies of the physician's prior/future treatment plan, including short and long term goals.
- Include the physician's and therapist's reports describing the types of services given, and the frequency of these services
- Is there a future plan of treatment? If yes, have the physician provide the anticipated length of treatment.
- Include copies of the operative report(s) of any related surgery, if applicable.
- Attach copies of applicable objective test results (MRI, x-rays, audiology tests, etc.).
- For children's therapies, please include copies of the referring pediatrician's and specialist physician's clinical records.
- 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
- If this appeal is being filed by your authorized representative on your behalf, include a copy of your signed and dated authorization documenting your permission for the authorized representative to act on your behalf

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

The Network/Claim Administrator will provide you with a written response to your request for review within approximately 15 days (for pre-service issues) or 30 days (for post-service issues) of its receipt of this completed Application and supporting documentation. If you disagree with the First Level Appeal determination, you may appeal the decision by filing a Second Level Appeal with the EBC at American

Airlines, Inc. **HOWEVER, YOU MUST REQUEST A FIRST LEVEL APPEAL WITH THE NETWORK/CLAIM ADMINISTRATOR AND RECEIVE ITS DETERMINATION BEFORE YOU MAY PROGRESS TO THE SECOND LEVEL APPEAL WITH THE EBC**. If you wish to appeal to the EBC, you must complete and sign an Application for Second Level Appeal and mail it, with a copy of the First Level Appeal determination letter, and with all supporting documentation, to the EBC. **Your Second Level Appeal must be completed and filed within 180 days of the date you receive the Network/Claim Administrator's decision on the First Level Appeal or your right to further appeal is waived**.

EMPLOYEE'S FIRST 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) $_____

In signing this form, I also authorize the release of all medical records and other information pertinent to this appeal to American Airlines, Inc., Plan Sponsor and Administrator of the American Airlines, Inc. benefit plans, the Network/Claim Administrator and its agents/delegates, including any health care professional(s) selected by them to assist with the appeal review.

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) THIS COMPLETED FORM AND ALL SUPPORTING MATERIALS TO YOUR APPLICABLE NETWORK/CLAIM ADMINISTRATOR:

FOR USPS REGULAR MAIL DELIVERY	FOR EXPRESS DELIVERY
UnitedHealthcare Appeals Unit	UnitedHealthcare Appeals Unit
PO BOX 740816	1355 South 4700 West, Suite 100
Atlanta, GA 30374-0816	Salt Lake City, UT 84104
	1.800.955.8095 (active employees and <65 retirees)
	1.800.638.9599 (≥ 65 retirees, both AA and TWA)
Blue Cross Blue Shield of Texas	A. Powell
PO BOX 833874	Blue Cross Blue Shield of Texas
Richardson, TX 75083-3874	1300 E. Pinecrest
	Marshall, TX 75266
	1.800.441.9188

IF YOUR APPEAL INVOLVES THE SUPPLEMENTAL MEDICAL PLAN, MAIL (or use express delivery) THIS COMPLETED FORM AND ALL SUPPORTING MATERIALS TO:

FOR USPS REGULAR MAIL DELIVERY	FOR EXPRESS DELIVERY
HealthFirst TPA	HealthFirst TPA
PO BOX 130217	821 ESE Loop323, Suite 200
Tyler, TX 75713-0217	Tyler, TX 75701
	1.800.711.7083

IF YOUR APPEAL INVOLVES FLEXIBLE SPENDING ACCOUNTS OR HSA, HRA, HIA, MAIL (or use facsimile transmission) THIS COMPLETED FORM AND ALL SUPPORTING MATERIALS TO:

FOR USPS REGULAR MAIL DELIVERY	FOR FACSIMILE TRANSMISSION
Your Spending Account Services	1-888-211-9900
P.O. Box 785040	
Orlando, FL 32878-5040	