AmericanAirlines®

APPLICATION FOR FIRST LEVEL APPEAL: U&P LIMITS, BENEFIT AMOUNTS, IN/OUT NETWORK, COB

THIS APPLICATION FOR FIRST LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING USUAL AND PREVAILING FEE LIMITS, IN v OUT OF NETWORK FEE LIMITS, CALCULATION OF BENEFITS, COORDINATION OF BENEFITS, 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 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 or Claim Processor. 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 or Claim Processor; otherwise, your right to both levels of appeal is waived.

Your appeal must include the following:

- Complete, date, and sign this APPLICATION FOR FIRST LEVEL APPEAL (both employee and patient, other than a minor, must sign this Application)
- Explain, in detail, why you believe your issue in question should be approved by the Network/Claim Administrator or Claim Processor
- Include all information and documents that you believe support your appeal
- Include copies of the treating provider's itemized billing(s) for the service or supply at issue
- Attach all Explanation of Benefit Statements (EOBs) and all correspondence relating to this issue
- Include all primary and secondary diagnoses and the patient history.
- For the service or supply at issue, include a copy of the complete operative report(s), related pathology report(s), procedure report(s) or other clinical documentation
- Include copies of all related test and lab results and anesthesia records, if applicable to your appeal
- If your appeal involves an out of network provider's fees, include records of all correspondence with such provider and with your Network/Claim Administrator and its Provider Relations group
- If your appeal involves calculation of benefits on the claim in question, include copies of the provider's billing and your EOBs
- If your appeal involves Coordination of Benefits, provide copies of your primary health plan carrier's EOBs, indicating their payment of benefits and how those benefits were calculated
- 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.

The Network/Claim Administrator or Claim Processor 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 OR CLAIM PROCESSOR AND RECEIVE ITS DETERMINATION BEFORE YOU MAY PROGRESS TO THE SECOND LEVEL APPEAL WITH THE PBAC**. 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 or Claim Processor'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):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 my appeal to the Network/Claim Administrator or Claim Processor.

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

United Healthcare Appeals Unit	**Blue Cross and Blue Shield of Texas**
PO BOX 740816	**PO BOX 833874**
Atlanta, GA 30374-0816	**Richardson, TX 75083-3874**
1-800-955-8095 (for active employees and under age 65 retirees)	**1-800-441-9188**
1-800-638-9599 (for age 65 and over retirees and TWA retirees)	

IF YOUR APPEAL INVOLVES THE SUPPLEMENTAL MEDICAL PLAN, MAIL THIS COMPLETED FORM AND ALL SUPPORTING MATERIALS TO THE CLAIM PROCESSOR:

HealthFirst TPA
PO BOX 130217
Tyler, TX 75713-0217
1-800-711-7083