AmericanAirlines®

EMPLOYEE BENEFITS COMMITTEE (EBC)

APPLICATION FOR SECOND LEVEL APPEAL: U&P LIMITS, BENEFIT AMOUNTS, IN/OUT NETWORK, COORDINATION OF BENEFITS

THIS APPLICATION FOR SECOND 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.

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, for your records, 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 Network/Claim 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 First Level Appeal determination letter from the Network/Claim Administrator or Claim Processor
- 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
- 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.

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 Network/Claim 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**