UNITED HEALTHCARE
APPLICATION FOR FIRST LEVEL APPEAL: MEDICAL NECESSITY OR INFERTILITY

THIS APPLICATION FOR FIRST LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING MEDICAL NECESSITY OF A PARTICULAR TREATMENT, PROCEDURE, OR SERVICE/SUPPLY, OR FOR ANY ADVERSE DETERMINATION REGARDING TREATMENT FOR INFERTILITY

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. 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
- Attach all Explanation of Benefit Statements (EOBs) and all correspondence relating to this issue
- Include all primary and secondary diagnoses and the patient history.
- Include clinical records of how and when the patient's condition(s) began
- Include clinical records of all prior treatments rendered for the condition(s) and the results of these treatments
- Include complete physician's clinical records for all physicians that have ever treated the patient for this or related condition(s)
- Include a statement of medical necessity from the treating physician explaining why he/she believes the service or treatment is medically appropriate and necessary for the patient's care
- For the service of supply at issue, include a copy of the applicable operative report(s), related pathology reports, and if applicable, pre/post-operative photos, visual fields, jaw measurements, etc., depending upon the type of condition(s) or treatment at issue
- Include copies of all related test and lab results and anesthesia records, if applicable
- Include records of any and all prior treatment plans, including what treatments were rendered, and what was the outcome of these treatments (drugs, procedures, surgeries, etc.)?
- Include records/documentation of what future treatment is planned, and what is the expected outcome (drugs, procedures, surgeries, etc.)?
- Include any published literature and/or documentation, if applicable, related to the service(s) or supply(ies) What is the frequency planned for the treatment and the expected duration, if applicable?
- 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. 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.

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 **Summary Plan Description**, 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 FOR THE GROUP HEALTH PLAN:

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 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:

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