UMR
APPLICATION FOR SECOND LEVEL APPEAL: MEDICAL NECESSITY OR INFERTILITY

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

IMPORTANT NOTICE:

YOU MUST COMPLETE THIS FORM AND PROVIDE ALL REQUESTED INFORMATION.

In order for the administrator 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 administrator. 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
- Explain, in detail, why you believe your issue in question should be approved by the administrator
- 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.

THEREFORE, INCLUDE ALL FACTS AND CIRCUMSTANCES THAT YOU WANT TO BE CONSIDERED WHEN YOUR SECOND LEVEL APPEAL IS REVIEWED. AFTER THE ADVERSE IS RENDERED 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 **Summary Plan Description**, 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) $_____

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 COMPLETED FORM AND SUPPORTING MATERIALS TO:

Post-Service Claim Medical Appeals:
UMR Claims Appeal Unit
PO BOX 30546
SALT LAKE CITY UT 84130-0546
Phone: 800-826-9781

Pre-Service Claim Medical Appeals:
UHC Appeals - UMR
PO BOX 400046
SAN ANTONIO TX 78229
Fax: 877-291-3248