UNITE HERE HEALTH
711 North Commons Drive
Aurora, IL 60504

Appeal Form

What if I need help understanding this denial? Call us at 1-844-484-4726 if you need help understanding this notice or if you have any questions on our decision to deny your prescription.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at 1-855-405-FUND(3863).

What if I don't agree with this decision? You have a right to appeal any decision for a prescription that is not provided or paid for in whole or in part.

How do I file an appeal? Within 6 months from the date of this notice, complete the Appeal Filing Form on the bottom of this page and send to the address on the form. (Make a copy for yourself)

What if my situation is urgent? Generally, an urgent situation is when your health may be at serious risk or, in the opinion of your physician; you may have pain that cannot be controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request a quicker appeal by calling 1-844-484-4726. Your review will most likely be finished within 72 hours.

Who may file an appeal? You or someone you name to act for you may file an appeal.

Can I provide additional information about my claim? Yes, you may supply additional information to help support your appeal**.** If you have any questions please contact the Hospitality Rx Appeals Reviewer at 1-844-484-4726.

What happens next? If you appeal, an Appeals Reviewer at Hospitality Rx will review the decision and provide you with a written determination. If they continue to deny your request, or you do not receive a timely decision, you may be able to request an appeal to the Fund and they will issue a final decision.

Other resources to help you: If you appeal, Hospitality Rx will review the initial decision. For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program may be able to help you.

You must mail or fax your appeal no later than 180 days from the date you received this notice:
The Appeals Subcommittee, UNITE HERE HEALTH, 711 North Commons Drive, Aurora, IL 60504 OR **Fax: 630-236-5232**

Patient name, DOB, ID number: _____

Date Claim was denied: see date on attached notice_____

Person filing appeal is (Circle one): Participant Provider Authorized Representative*

**If you are the Authorized Representative, you must also submit an Authorized Representative form. Call the plan at 1-630-236-5100 to get the form. In urgent situations, the form is not required*

Contact information of person filing appeal (if different from patient)

Name of person filing appeal: _____

Signature:_____

Address: _____

Daytime phone:_____ Fax:_____

Are you requesting an urgent appeal? Yes No

Is this appeal about a medication you are currently taking: Yes No

Explain why you disagree with this decision. You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your appeal**. Please attach explanations if needed**

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