Post-Service Appeal Request Form

American Postal Workers Union Health Plan, AFL-CIO

Please fill out the following information when you are requesting a review of an adverse benefit determination or claim denial by APWU Health Plan. If you are appealing on behalf of someone else, please also include the Designation of Authorized Representative Form with this request.

Request Information

1. **Today's Date:** ______________________
2. **Patient Name:** ______________________
3. **Patient Date of Birth** *(Month/Date/Year)*: ______________________
4. **Member ID#:** ______________________
5. **Member Name:** ______________________
6. **Plan Name:** ______________________
7. **Date of Service of Claim:** ______________________
8. **Claim Control Number:** *(noted on your EOB)* ______________________
9. **Total Billed Amount of Claim: $** ______________________
10. **Provider Name:** ______________________

11. **Are you including medical records with your request? Yes or No** ____________

    Please Note: *If no medical documentation is submitted, our review will be based on the information we currently have on file. Medical records consist of office notes, laboratory result, operative notes/reports and medical history.*

12. **Name, address and phone number of person filling out the Form for APWU Health Plan to contact with any questions:**

    Name: ______________________ **Address:** ______________________

    Phone Number: ______________________

    Alternate Phone Number: ______________________

13. **Description of Dispute:**

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Please submit your completed form, along with any supporting documentation, electronically via Fax number below, or mail to:

High Option:

Fax Number: 410-424-1564

Or mail to:

APWU Health Plan Appeals
Attn: Public Relations Department
PO Box 8660
Elkridge, MD 21075

Consumer Driven Option:

Fax Number: 801-994-1083

Or mail to:

United Healthcare Appeals
PO Box 740816
Atlanta, GA 30374-0816

Customer Service Email: custserv@apwuhp.com
Website: www.apwuhp.com

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