Information Request Form - Appeals

American Postal Workers Union Health Plan, AFL-CIO

About You

Member ID: _____

Your Name: _____ **Date of Birth** *(Month/Date/Year)*: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Alternate Phone Number: _____

Information Requested

Please check the plan under which you are requesting records:

☐ **High Option** ☐ **Consumer Driven Option**

Please provide a detailed description, including claim number(s) and/or dates of service for which you are requesting records:

_____

_____

_____

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_____

I request a copy of records relevant to the benefit determination made by APWU Health Plan. I understand that the request for records is not considered an appeal as described in the Disputed Claims section of my plan brochure or other applicable plan document.

Information to be released to:

☐ **Self** ☐ **Other** *(Must be designated as Authorized Representative. Please fill in correct contact information below. If necessary, please also include the Designation of Authorized Representative Form.)*

Mail to:

Name: _____ **Date** *(Month/Date/Year)*: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Patient or Legal Representative Signature: _____

Relationship to Patient *(i.e. parent, legal guardian, power of attorney, etc.)*: _____

Note: *If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.*

Please retain a copy for your records and return the original signed form, 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