



**CLEVELAND CLINIC / AKRON GENERAL
EMPLOYEE HEALTH PLAN (EHP)
APPEAL/EXPEDITED APPEAL FORM**

Date: _____

Employee/Contract Holder: _____ Plan ID No. _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

PLAN INFORMATION (Check plan(s) for review)

- | | | | |
|-----------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Ohio EHP | <input type="checkbox"/> Florida EHP | <input type="checkbox"/> Out-of-Area EHP | <input type="checkbox"/> Akron EHP |
| <input type="checkbox"/> STAFF | <input type="checkbox"/> NON-STAFF | <input type="checkbox"/> PHARMACY | <input type="checkbox"/> Akron USW EHP |
| <input type="checkbox"/> DENTAL | <input type="checkbox"/> VISION | <input type="checkbox"/> OTHER _____ | |

Patient Name: _____ Provider: _____

Physician/Hospital/Facility

Date(s) of Service: _____ / _____ / _____

Note: Separate Appeal form must be used unless dates are related to the same circumstance (e.g. hospital stay)

APPEAL INFORMATION

INFORMATION REQUIRED TO BEGIN APPEAL PROCESS

- Attach copies of itemized bills/statements (balance forward statement cannot be accepted), Explanation of Benefits statement from TPA and if applicable, medical records (which must be obtained from the medical records department of the hospital/physician you were treated). **IF YOU DO NOT INCLUDE THESE ITEMS, YOUR APPEAL WILL BE RETURNED TO YOU.**
- Filing limitations – all claims/appeals must be filed no later than 180 days from the initial date of denial.

Briefly summarize the circumstances surrounding your appeal (or attach a copy of your summary to this form):

Employee/Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this appeal:

Signed: _____ Date: _____

FORWARD COMPLETED FORM TO:
Cleveland Clinic / Akron General
Employee Health Plan
3050 Science Park Drive / AC332b
Beachwood, OH 44122
Fax: 216.448.2053

FOR BENEFITS USE ONLY: Received: _____
