Participant Benefit Claim Appeal

Return this form to:

Michigan Conference of
Teamsters Welfare Fund
Attn: Appeals Department
2700 Trumbull
Detroit, MI 48216

If you are not satisfied with the MCTWF's decision to deny your benefit claim in whole or in part, you have the right to appeal that decision and have it reviewed by the MCTWF's Trustees (the reverse side of this form describes the MCTWF's appeal process). If you would like your case reviewed, please fill out this form and return it to the Appeals Department at the address above, within 180 days from the date the denial of benefits was received. See back of form for additional information regarding 180-day filing limit. Please include any written comments, documents or other information in support of your appeal, along with a copy of your denial letter or explanation of benefits form.

Participant Name:			**Participant's Contract No.:**
Street Address:			**Claim Number(s):**
City:	**State:**	**Zip Code:**	**Patient's Name:**
Daytime Phone Number:			**Appellant's Name:**
			Date(s) of Service:

Please state the issue you are appealing, the basis for your appeal (the reason you disagree with the decision) and what action you feel should be taken: **Attach additional pages if necessary**

Appellant's Signature:	**Date:**

Important Information about Your Appeal Rights

What if I need help understanding this Explanation of Benefits ("EOB")/letter? Contact the Michigan Conference of Teamsters Welfare Fund's ("MCTWF") Member Services Call Center at 800-824-3158 if you need assistance understanding this EOB or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part) within 180 days after receipt of any EOB denying benefits. **NOTE: Pursuant to the federal Joint Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants and Beneficiaries Affected by the COVID-19 Outbreak (Federal Register page 26351), the 180-day appeal period will not begin to run until 60 days following termination of the current COVID-19 National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak**.

How do I file an appeal? Complete the *Appeal Filing Form* below and send this document to: MCTWF, 2700 Trumbull Avenue, Detroit, MI 48216, Attention: Appeals Department. See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours of receipt. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by completing the *Appeal Filing Form* below.

Who may file an appeal? You or someone you name to act on your behalf (your authorized representative) may file an appeal. You must complete an Individual Authorization to Release Protected Health Information naming your authorized representative. The form is available by contacting MCTWF's Member Services Call Center or on MCTWF's website at www.mctwf.org.

Can I provide additional information? Yes, you may submit with your appeal written comments, documents, or other information in support of your appeal.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting MCTWF, 2700 Trumbull Avenue, Detroit, MI 48216, Attention: Member Services Department.

What happens next? If you appeal, MCTWF's Trustees will review MCTWF's initial determination and provide you with a final, internal adverse benefit determination. The Trustees' determination may be subject to an external review, upon your request, by an independent third party. If you are so entitled, the third party will review the Trustees' decision and issue a final determination.

Other resources to help you: For help about your 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 can help you file your appeal. Contact Office of Financial and Insurance Regulation, HICAP, 611 W. Ottawa Street, Lansing, MI 48933, (877) 999-6442.

Appeal Filing Form

Name of Person Filing Appeal: _____ **Enrollee ID #:** _____

Circle One: Covered Person Patient Authorized Representative

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

Address: _____ Daytime Phone: _____ Email: _____

If person filing appeal is other than patient, patient must indicate authorization by signing here:

_____

Claim Number: _____ **Are you requesting an urgent appeal?** □ Yes □ No

Briefly describe 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 claim):

_____

_____

Send this form and your denial notice to: Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216, Attention: Appeals Department.

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.