REQUEST FOR APPEAL OF HEALTH CARE SPENDING ACCOUNT CLAIM DECISION
OTHER

HIGHMARK. Delaware

1 **Please check one of the following:**

☐ I want to appeal my own claim. (Skip to #2.)

☐ I want to appeal a claim on behalf of another. (Participant must complete, sign, and date authorization in section b.)

a. Please provide the following information:

Your name: _____ Daytime phone: _____

Your relationship to the participant: _____

b. Authorization

I authorize (print name of designation person): _____ to act on behalf concerning this appeal.

Participant's signature: _____ Date: _____

2 **Please complete participant information:**

Participant's name: _____ Social Security #: _____

Employer: _____ Daytime phone: _____

3 **Please identify reason for appeal.** If possible, attach copies of any paperwork related to this claim.

_____

_____

_____

_____

_____

_____

4 **PLEASE SIGN AND DATE BELOW.**

Participant's signature: _____ Date: _____

Thank you for completing this Request for Appeal. We will review your appeal and notify you of the outcome. (Please see the "How to Appeal a Health Care Spending Account Decision" information provided to you with your claim denial for appeal timeframes.)