

CLAIMANT APPEAL REQUEST FORM

You may use this form to appeal a coverage decision or you can request an appeal by following the appeal procedure outlined in your certificate of coverage.

PLEASE PRINT

Insured Name:	Claimant (Patient) Name:
Mailing Address (Include Street Address, City, State, Country, and Postal Code):	Certificate #:
	Home Phone:
	Work Phone:
	Home Country:
Authorized Representative*:	Email address:
Service or Claim that was denied:	Date of Service:
Provider Name:	Claim #(s):
Please explain your appeal and your expected resolution. (You may attach extra pages if you need more space.) PLEASE ATTACH ANY DOCUMENTS OR MEDICAL RECORDS THAT YOU BELIEVE SUPPORT YOUR APPEAL.	

Member (or Representative) signature

Date

Relationship to Member (if Representative)

IMPORTANT: You must mail or email this form to the following address for prompt resolution of your request.

Mail to:
Tokio Marine HCC Appeals
Box No. 2058
Farmington Hills, MI 48333-2005
U.S.A

OR

Email to:
mis-appeals@tmhcc.com

**If you are requesting that a Third Party handle your appeal , please attach a signed and completed Authorization Form.*