Medical Insurance Services Group
Box No. 2005
Farmington Hills, MI 48333-2005
1-800-605-2282 / 317-262-2132

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:	
Provider Name:	Claim #(s):
Date of Service:	

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: This form must be returned to the following address for prompt resolution of your request:

Tokio Marine HCC – MIS Group
PO Box 2005
Farmington Hills, MI 48333-2005

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