

EBPA APPEAL FORM

Today's date:	Provider Name:	Provider Tax ID Number:
Appeal Contact Name:		Appeal Contact Phone Number:
Provider Address:		

APPEAL STATEMENT

I hereby request a review of the adverse benefit determination described below and understand the receipt of this form by EBPA LLC constitutes a formal appeal.

PATIENT INFORMATION

Please print clearly and complete all of the information requested below.

Participant Name	Birth date: / /	Address:	Home phone no.:
Group Number:	ID Card Number:	Employer:	
Patient Name	Birth date: / /	Address:	Home phone no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Date of Service being appealed:	Claim Number (if applicable)	Condition/Diagnosis	

APPEAL DESCRIPTION

Please describe the name/reason for your appeal and any facts you feel should be considered in the review of your appeal. If the problem involves unpaid bill, please attached a copy of the bills and EOBs. Also submit any relevant documentation you feel may assist in the appeal determination. **Please remit this appeal form to the EBPA mailing address contained on the member's identification card.**

