Long-Term Care Claim Appeal Request

How to File an Appeal

Before filing an appeal, we encourage you to contact the Long-Term Care Customer Service Department at the number below to discuss the details of your claim denial. If a Customer Service Representative cannot resolve your inquiry over the phone, you will be prompted to proceed with the formal appeal process using this form as a guide.

	-						
Insured Name:		_ [Date of Birth:				
Policy Number(s):		_ (Current State of Residence:				
Care P	rovider(s):						
Date(s)	of Service in Question:						
	Select the option that best describes your ap You disagree with our decision and request submitted.			ne information you already			
	You disagree with our decision and have additional information for us to consider. Check the following boxes to describe what you are sending with this form.						
	☐ Cognitive testing		Medical records	☐ Service plans			
	Doily home hoolth care visit notes	_					
	 Daily home health care visit notes 		Healthcare provider assess	ments			
	Other: If you would like us to request the above inf contact information and make sure to enclose	ormat	tion from a physician or provid	der, include below any necessary			
	Other: If you would like us to request the above inf	ormat se a c	tion from a physician or provio ompleted Claims Authorizatio	der, include below any necessary on for Medical Information form,			
	Other: If you would like us to request the above inf contact information and make sure to enclos which is included for your convenience.	ormat se a c	tion from a physician or provion of the completed Claims Authorization Telephone Number:	der, include below any necessary on for Medical Information form,			
Step 3:	Other: If you would like us to request the above inf contact information and make sure to enclos which is included for your convenience. Physician/Provider Name:	ormat	tion from a physician or provion of provion of the completed Claims Authorization Telephone Number:	der, include below any necessary on for Medical Information form,			
	Other: If you would like us to request the above inf contact information and make sure to enclos which is included for your convenience. Physician/Provider Name:	ormatise a co	tion from a physician or provious ompleted Claims Authorization Telephone Number: ate piece of paper (not the baction)	der, include below any necessary on for Medical Information form,			
	¹If you would like us to request the above inf contact information and make sure to enclos which is included for your convenience. Physician/Provider Name: Address: Summarize the reason for your appeal on a Submit forms and supporting documents in a • Upload at: https://www.bankerslife.com/se • Mail to the address listed below • Fax to the number listed below We will acknowledge your request within	ormatise a consequence of the co	tion from a physician or provious ompleted Claims Authorization Telephone Number: ate piece of paper (not the bacter to the following ways: support/document-upload/	der, include below any necessary on for Medical Information form, ack of this form).			
Step 4:	¹If you would like us to request the above inf contact information and make sure to enclos which is included for your convenience. Physician/Provider Name: Address: Summarize the reason for your appeal on a Submit forms and supporting documents in a • Upload at: https://www.bankerslife.com/se • Mail to the address listed below • Fax to the number listed below We will acknowledge your request within	ormatice a control of the control of	tion from a physician or provide ompleted Claims Authorization Telephone Number: ate piece of paper (not the base of the following ways: support/document-upload/ weeks of receipt. Please allow writing to the insured's addres	der, include below any necessary on for Medical Information form, ack of this form).			

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Claims Authorization for Medical Information

Conforms to HIPAA Privacy Rule

This is a medical release of information form. This form is used to allow your medical information to be released to Bankers Life and Casualty Company for the purpose of reviewing your claim for benefits.

1.	My Information – the individ	ual whose medica	al information is to be rel	eased					
Printed Name		Date of Birth	Soc. Sec. Number (last 4 digits) Policy Number						
Ad	dress		City	State	Zip				
2.	Disclosing Party – the party of Any physician or other health of pharmacy benefit manager or p Social Security Administration	care provider, hosp harmacy-related or	ital, clinic, medical facility ganization, insurance com	, clinical lab,					
3.	Description of my information authorized for release Any/all information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse.								
4.	Purpose of Authorization – how my information will be used To administer benefits under a policy or certificate of insurance.								
5.	Duration or Authorization Twenty-four (24) months from	the date written be	clow, unless I specify an ear	rlier date here	e:				
6.	Receiving Parties – the partie Bankers Life and Casualty Con								
7. 8. <i>A</i>	 Important information – review carefully before signing Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage. This Authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: LTC Claims Administration P.O. Box 1902, Carmel, IN 46082-1902. The Receiving parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected. I understand that I (or my authorized representative) have a right to a copy of this Authorization and that a photocopy or facsimile is as valid as the original. Obtain a large print version of this form by calling 800-621-3724 and requesting form 18727-LARGE Approval – must be signed and dated by me or my Legal Representative* to be valid 								
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Prii	nted Name		Relationship to the insur	ed					
Sig	nature		Date Signed						

*Legal Representative must provide documentation of legal authority

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