District No. 9, I. A. of M. & A. W. Welfare Trust
12365 St. Charles Rock Road ▪ Bridgeton, MO 63044
314-739-6442 ▪ 888-739-6442 ▪ 314-739-2374, fax
www.d9trusts.org

HEALTH & WELFARE APPEAL FORM

A claim that has been wholly or partially denied ("denied" includes application of co-pay or deductible), the member or covered person may appeal this decision. To challenge the decision the member or covered person must file an appeal within 180 days of the date you receive the decision. To review your case, please complete this form in its entirety and submit to:

DISTRICT NO. 9, I. A. OF M. & A. W. WELFATE TRUST
Attn: Board of Trustees
12365 St. Charles Rock Road
Bridgeton, MO 63044

- ✓ Please attach a copy of the denial letter or explanation of benefits.
- ✓ Submit all documents, records, and other relevant information to consider this appeal. For example, a letter from a medical practitioner, information relating to a specific product or service for which you are seeking coverage, evidence of any extenuating circumstances that have a direct impact on the complaint.
- ✓ If this form is completed by the rendering provider, the appeal must be filed with the attached authorization that must be signed by the claimant. Please visit our website at www.d9trusts.org or contact the Welfare Office for the *Designation of Authorized Representation for Appeal and Authorization for Release Health Information Form* if needed.

______________________________ ______________________________
Member Name Member ID Number

____
Patient Name

____
Claim Number(s)

______________________________ ______________________________
Signature of Patient or Authorized Representative Date

Upon receipt of your completed appeal, the Fund Office will notify you in writing of the date your appeal will be discussed by the Board of Trustees.

Please state your reason for disagreement with the decision.

Please state what action you feel should be taken.

DESIGNATION OF AUTHORIZED REPRESENTATIVE FOR APPEAL AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Section A: Member / Claim Information

Your Name: ______________________ Member Name: ______________________

Patient Name: ______________________ Member ID Number: ______________________

Check the box(es) that apply: I am the ☐ member ☐ patient ☐ legal guardian of the patient

Claim Number: ______________________ Date(s) of Service: ______________________

Section B: Authorized Use and / or Disclosure

I do hereby designate the individual or entity identified below as my Authorized Representative for purposes of appeal of the above claim. I understand and agree that my Authorized Representative will receive all information and notifications from the District No. 9, I.A.M.A.W. Welfare Trust and will be entitled to receive all relevant documents regarding this claim, including information and documents containing my Protected Health Information which is protected by the HIPAA Privacy Rules. I understand that in the absence of a contrary direction from me, the District No. 9, I.A.M.A.W. Welfare Trust will direct all information and notices regarding the appeal, to which I am otherwise entitled, to my Authorized Representative only. I further understand and agree that I am hereby waiving my individual right to appeal this claim and that I am bound by the decision rendered to my Authorized Representative with respect to this claim.

I understand that the District No. 9, I.A.M.A.W. Welfare Trust, pursuant to the HIPAA Privacy Rules, may not generally disclose my health information to other individuals without my written authorization. For this reason, I authorize the District No. 9, I.A.M.A.W. Welfare Trust to discuss and disclose my health information to my Authorized Representative that I have named below. This disclosure will be limited to the purpose of the appeal of the above denied claim.

Designation of Authorized Representative:

Name: ______________________

Contact Name and Title: ______________________

(If Authorized Representative is not and individual)

Address: ______________________

Phone Number: ______________________ Fax Number: ______________________

Section C: Expiration

This designation of my Authorized Representative and authorization to release information to my Authorized Representative will automatically expire upon the final resolution of the above claim and appeal to which this authorization relates.

Section D: Important Information Concerning Your rights

1. You may revoke this Authorization at any time. However, any revocation will not apply to the extent that we have already taken action in reliance upon your Authorization. Your request for revocation must be in writing. We will provide you with a revocation form at your request.
2. We may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits upon your signing this Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal health information privacy laws.
4. You are entitled to a signed copy of this Authorization.

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this designation and authorization. I confirm that this designation and authorization is at my request. I understand that, by signing this form, I am confirming my designation of authorized representation to the entity or individual named in Section B and am confirming that my personal health information may be used and/or disclosed to the entity or individual named in Section B.

Signature: ______________________ **Date:** ______________________

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE WELFARE FUND AT:

DISTRICT NO. 9, I. A. OF M. & A. W. WELFARE TRUST

Attn: Appeals Department

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