

## Appeal Request Form

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

### CLAIM DATA (All fields are required)

#### Member Information

|                                      |          |
|--------------------------------------|----------|
| Member ID or Social Security Number: |          |
| Member Name (Last Name, First Name): |          |
| Date of Birth:                       |          |
| Member Address (Street Address):     |          |
| City, State, Zip:                    |          |
| Member Daytime Phone Number:         | (      ) |

#### Authorized Representative if not member

*If you are requesting an appeal on behalf of the member, an Authorization to Release Form must be completed, and either be submitted with this form or on file with ARBenefits.*

#### Requester Information

|   |          |
|---|----------|
| Requester Name (Last Name, First Name): |          |
| Requester Address (Street Address):     |          |
| City, State, Zip:                       |          |
| Requester Daytime Phone Number:         | (      ) |

### MEDICAL APPEALS MUST ALSO INCLUDE:

- Letter describing the reason for your appeal.
- Copy of Denial Notice (Explanation of Benefits)
- Documentation such as bills, medical records, or other documentation that may assist us in our review.
- Date of Service: \_\_\_\_\_

### TYPE OF APPEAL

|                                   |                                   |  |                                      |  |
|-----------------------------------|-----------------------------------|--|--------------------------------------|--|
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Wellness | <input type="checkbox"/> Medical (see above) | <input type="checkbox"/> Eligibility | <input type="checkbox"/> Flexible Spending Account |
|-----------------------------------|-----------------------------------|--|--------------------------------------|--|

**All appeal forms must be signed and dated, or they will not be processed.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

MAIL OR FAX FORM AND ACCOMPANYING MATERIALS TO:  
 Department of Transformation and Shared Services – Employee Benefits Division  
 P.O. Box 15610 – Little Rock, AR 72231 – ATTN: Appeals Department – FAX: 501-683-6516