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

☐ Pharmacy ☐ Medical (see above) ☐ Eligibility ☐ 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