CLEVELAND CLINIC / AKRON GENERAL
EMPLOYEE HEALTH PLAN (EHP)
APPEAL/EXPEDITED APPEAL FORM

Date: ______________________________

Employee/Contract Holder: __________________________ *Plan ID No.*______________________

Address: __________________________ *City:*__________________ *State:*__________ *Zip:* ______

*Home Phone: (______)*_______________ *Work Phone: (______)*_______________ *Ext:* ______

PLAN INFORMATION (Check plan(s) for review)

☐ *Ohio or Akron Non-Staff*	☐ *Out-of Area EHP*	☐ *Pharmacy*
☐ *Staff*	☐ *Akron ONA EHP*	
☐ *Florida EHP*	☐ *Akron USW EHP*	☐ *Other:* ______________________

Patient Name: ______________________________ Provider: ______________________________
Physician/Hospital/Facility

Date(s) of Service: ______________/______________/______________/______________

Note: Separate Appeal form must be used unless dates are related to the same circumstance (e.g. hospital stay)

APPEAL INFORMATION

INFORMATION REQUIRED TO BEGIN APPEAL PROCESS

- Attach copies of itemized bills/statements (balance forward statement cannot be accepted), Explanation of Benefits statement from TPA and if applicable, medical records (which must be obtained from the medical records department of the hospital/physician you were treated). **IF YOU DO NOT INCLUDE THESE ITEMS, YOUR APPEAL WILL BE RETURNED TO YOU.**
- Filing limitations – all claims/appeals must be filed no later than 180 days from the initial date of denial.

Briefly summarize the circumstances surrounding your appeal *(or attach a copy of your summary to this form):*

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Employee/Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this appeal:

*Signed:*____ *Date:*______________________

FORWARD COMPLETED FORM TO:

Ohio:
Mutual Health Services
P.O. Box 89472
Cleveland, OH 44101-6472
Fax: 440.878.5451

Florida & Out-of-Area:
Claims Appeal Unit
P.O. Box 30546
Salt Lake City UT 84130-0546

FOR BENEFITS USE ONLY: Received:______________
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Revised 5.23.18