Member appeal filing form

Who's completing the form?

Your name	
Your relationship to patient	☐ Patient/Self ☐ Covered person/Parent ☐ Authorized representative
Your address	
Your phone number	
Your email address	

If you are not the patient, the patient must provide authorization to release information by signing here

Patient signature	Date

Member information

Member/patient name		Date of birth	
Member ID number			
Employer group name		Employer group number	

Claim information

Claim number		Date EOB received (Explanation of Benefits)	
Provider name		Date of service	

Are you receiving a bill from your provider for the amount showing on your EOB?	☐ Yes ☐ No

If yes, please enclose the billing statement and your EOB with the appeal request. If no, you may wish to wait before appealing to see if the provider bills you.

Is this your second appeal?	☐ Yes ☐ No

(This means you received a denial of your post-service claim appeal and are including additional information for consideration.)

Briefly describe what you are appealing and your expected outcome. Attach additional information to support your appeal.

Please complete this entire form and send it with a copy of your EOB to:

Surest – Surest Member Appeals
PO Box 31270
Salt Lake City, UT 84131

Incomplete forms may be returned or dismissed.

Questions?

Call the number on the back of your Surest member ID card.

Web Benefits.Surest.com
Surest Member Services hours
6 am – 9 pm CST
Language assistance services are available