Appeals
FORM

StayWell INSURANCE

An appeal is a request by the Member or the Member's Authorized Representative for reconsideration of an Adverse Determination of a health service request or benefit that the Member believes he or she is entitled to receive. Please explain below why you believe the initial determination should be reconsidered, based on the benefit provisions of your health plan. Attach supporting documents such as medical records, physician letters, bills, receipts and any other form that would serve the same purpose.

Last Name	**First Name**	
Member Number	**Subscriber**	**Effective Date**
Employer	**Name of StayWell Representative who assisted you**	
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )
Email Address		

DETAIL OF APPEAL

Release of Confidentiality: My signature below indicates that StayWell has my permission to discuss the details of my or my minor enrolled dependents' concern or appeal to all parties involved in order to resolve these issues.

MEMBER/AUTHORIZED REPRESENTATIVE SIGNATURE
(Parent/Guardian if a minor)

DATE SIGNED

STAYWELL INSURANCE DEPARTMENT HEAD

DATE SIGNED

QUALITY ASSURANCE MANAGER

DATE SIGNED

520 Route 8 Maite, Guam 96910