



P.O. Box 30192 Salt Lake City, UT 84130-0192 801-442-5038/800-538-5038 selecthealth.org

Appeal and Complaint Form

Subscriber name _____ Subscriber ID# _____
 Street address _____ City _____ State _____
 ZIP _____ Home Ph# (_____) _____ Work Ph# (_____) _____
 Plan _____ Employer _____
 Provider _____ Patient's name (person mentioned in the appeal) _____
 Date of Birth ____/____/____ Date(s) of Service ____/____/____

A. EXPLANATION OF COMPLAINT

B. WHAT WRITTEN AND/OR ORAL COMMUNICATION HAVE YOU RECEIVED? FROM WHOM?

C. EXTENUATING CIRCUMSTANCES OR ADDITIONAL INFORMATION

D. WHAT IS YOUR EXPECTATION FOR RESOLUTION?

SIGNATURE

Please attach copies of any supporting documents (referrals, claims, itemized bills, and/or letters from doctors/providers, etc.). **You may fax this information to 801-442-0762. SELECTHEALTH IS AUTHORIZED TO INVESTIGATE MY COMPLAINT. I UNDERSTAND THAT THIS MAY NECESSITATE A REVIEW OF THE MEDICAL AND FINANCIAL RECORDS RELATING TO MY HEALTH.**

Signature _____ Date ____/____/____
Subscriber or Patient

Free interpreting services may be provided upon request. Se ofrecen servicios de interpretacion gratis a solicitud.