



4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 1-801-442-5038/1-800-538-5038 www.selecthealth.org

## Appeal and Complaint Form

Insured's Name \_\_\_\_\_ Subscriber ID# \_\_\_\_\_  
 Address \_\_\_\_\_ Home Ph# \_\_\_\_\_ Work Ph# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Plan \_\_\_\_\_  
 Employer \_\_\_\_\_ Provider \_\_\_\_\_  
 Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date(s) of Service \_\_\_\_\_

### 1. Explanation of complaint

### 2. What written and/or oral communication have you received? From whom?

### 3. Extenuating circumstances or additional information

### 4. What is your expectation for resolution?

### Signature

Please attach copies of any supporting documents (referrals, claims, itemized bills, and letters from doctors/providers, etc.). **You may fax this information to 1-801-442-4568. SELECTHEALTH<sup>SM</sup> 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 \_\_\_\_\_

*Insured or Patient*

Free interpreting services may be provided upon request.

Se ofrecen servicios de interpretacion gratis a solicitud.