HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
main 317 262 2132 web www.hccmis.com

CLAIMANT APPEAL REQUEST FORM

You may use this form to appeal a coverage decision or you can request an appeal by following the appeal procedure outlined in your certificate of coverage.

PLEASE PRINT

Insured Name:	Claimant (Patient) Name:
Mailing Address (Include Street Address, City, State, Country and Postal Code:	Certificate #:
	Home Phone:
	Work Phone:
	Home Country:
Authorized Representative*:	Email address:

Service or Claim that was denied:	
Provider(s) Name:	Claim #(s):
Date(s) of Service:	

Please explain your appeal and your expected resolution. (You may attach extra pages if you need more space.) PLEASE ATTACH ANY DOCUMENTS OR MEDICAL RECORDS THAT YOU BELIEVE SUPPORT YOUR APPEAL.

Member (or Representative) signature _____ Date _____

Relationship to Member (if Representative) _____

IMPORTANT: This form must be returned to the following address for prompt resolution of your request.

HCC Medical Insurance Services
PO Box 2005
Farmington Hills, MI 48333-2005

*If you are requesting that a Third Party handle your appeal, please attach a signed and completed Authorization Form.