

Claimant Appeal Request Form

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

PLEASE PRINT

Insured Name:	Claimant (Patient) Name:
Mailing Address (Include Street Address, City, State, Country, and Postal Code):	Policy/Certificate #:
	Home Phone:
	Work Phone:
	Home Country:
Authorized Representative*:	Email Address:
Service or Claim That Was Denied:	Date of Service (mm/dd/yyyy):
Provider Name:	Claim #(s):
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: You must mail or email this form to the following address for prompt resolution of your request.

Mail to:
 WorldTrips Appeals
 Box No. 2058
 Farmington Hills, MI 48333-2005
 U.S.A

OR

Email to:
appeals@worldtrips.com

**If you are requesting that a third party handle your appeal, please attach a signed and completed "Authorization Form For Use and/or Disclosure of Protected Health Information" form that can be downloaded by visiting <http://worldtrips.com/downloads>.*