WESTERN GROWERS HEALTH

# CLAIM APPEAL

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|---|---|
| Employee Name | HCID# Employee |
| Dependent Name (If Applicable) | Claim# |
| Provider Name | Date Of Service |
| Employer | **Western Growers Health Use Only** |

I. Date claim was denied _____ **(PLEASE NOTE: A request for review of the denied claim must be received within 180 days from the date the notice of denial was mailed to you as indicated on the postmarked envelope.)**

II. Please describe as completely as possible the reasons for your claim(s) appeal:

III. Please indicate the section of your SUMMARY PLAN DESCRIPTION, upon which you are basing your appeal:

IV. Is there any other information you would like us to consider in reviewing your appeal? Please explain below or attach any other documents you may have to support your appeal.

If all the necessary documents are received promptly, it is anticipated that we will review your appeal within 30 days of receipt of it and advise you in writing of our decision.

| | |
|---|---|
| Appeal Submitted By | Date |
| Address | Phone Number |
| Email | Fax Number |

**All sections must be completed before the appeal process can be initiated.**
**Incomplete forms will delay a decision.**
**WESTERN GROWERS HEALTH CLAIMS PLAN ADMINISTRATOR | P.O. Box 2130, Newport Beach, CA 92658**