IDSC Quality Review Unit Appeal Form

To appeal the denial of your benefits, please complete this form and return it in the enclosed self addressed envelope within 180 days from your receipt of your original denial letter. If your appeal is not received within 180 days from your receipt of your original denial letter the original denial will be upheld.

Please attach all pertinent medical information

Claim Number:	**Social Security Number:**	
Last Name:	**First Name:**	**Middle Initial:**
Street Address		
City:	**State:**	**Zip:**
Home Phone:	**Work Phone:**	

Please provide name and phone number of treating physician(s)

Provider Name: **Address:**	**Phone Number** **Specialty:**
Provider Name: **Address:**	**Phone Number:** **Specialty:**
Provider Name: **Address:**	**Phone Number:** **Specialty:**

Please state specifically why you are requesting an appeal of your benefits. Use the back of the form if necessary or attach a letter if additional space is needed.

Do you have additional medical information to submit that is not attached to the form? _____

If yes, please submit additional medical information as soon as reasonably possible.

Employee Certification:

I hereby certify that the information provided is complete and accurate to the best of my knowledge.

Employee Signature:_____ Date:_____

Please mail completed form in the enclosed envelope to:

IDSC Quality Review Unit
P.O. Box 14626
Lexington, KY 40512
Phone - 866-276-2278
Fax 1-866-856-5065