CHRISTIAN BROTHERS SERVICES
1205 Windham Parkway
Romeoville, IL 60446-1679
cbservices.org

Medical Appeal Request Form

You have the right to have an adverse benefit determination reviewed. You or you representative may appeal our decision verbally or in writing. An appeal request must be received within 180 days of the benefit decision.

To file your appeal verbally contact:	**To file your appeal in writing, fax or mail this form to:**
Call the number on your Explanation of Benefits.	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST 1205 WINDHAM PARKWAY ROMEOVILLE IL 60446-1679 FAX: 1-630-378-2504

Member Appeal is being filed by:

☐ Member ☐ Authorized Representative (indicate relationship to member) _____

Has this benefit determination been previously appealed? ☐ Yes ☐ No

Signature _____ **Date** _____ **Phone** _____

Information Required to Review Appeal

*Required Fields

Patient Information

*Patient name | *Patient date of birth

*Member name | *Member Group ID #

*Service/Code(s) | *Date(s) of service

Provider Information

*Provider name | *Address

Tax ID # (Optional) | *City, State and Zip Code

*Provider Contact Name | *Telephone Number

Appeal Information

Description of Appeal: Provide any pertinent information that relates to the appeal including any relevant medical information and the reason you believe out benefit decision was incorrect. Submit this information as an attachment if additional space is needed.

Failure to submit supporting documentation may limit our ability to review this appeal.