The Christian Brothers Employee Benefit Trust
1205 Windham Parkway / Romeoville, IL 60446-1679

Important Information about Your Medical Appeal Rights

This document contains important information that you should retain for your records.

This document serves as notice of an adverse benefit determination. We have declined to provide medical benefits, in whole or in part, for the requested treatment or service. If you think this determination was made in error, you have the right to appeal.

What if I need help understanding this denial? Contact us at the number on your Explanation of Benefits or Identification Card if you need assistance understanding this notice of our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Send in the reverse side of this form within 180 days. See your booklet.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by contacting us at the number on your Explanation of Benefits or Identification Card.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. Contact us at the number on your Explanation of Benefits or Identification Card.

Can I provide additional information about my claim? Yes, you may supply additional information. Send correspondence to:
CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST
1205 WINDHAM PARKWAY
ROMEOVILLE IL 60446-1679
-OR- contact us at the number on your Explanation of Benefits or Identification Card.

Can I request copies of information relevant to my claim? Yes. In addition, you are entitled to receive (free of charge) copies of any new or additional information that we used or created in connection with your appeal. If you would like this information, we strongly encourage you request it at the time you file your appeal. This will enable us to provide the information so that you will have a reasonable opportunity to respond to it before we decide the appeal, should you wish to do so. You may request copies by contacting us at the number on your Explanation of Benefits or Identification Card.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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Medical Appeal Request Form

You have the right to have an adverse benefit determination reviewed. You or your 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 ☐ Provider ☐ Other 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

Appeal Information

Description of Appeal: Provide any pertinent information that relates to the appeal including any relevant medical information and the reason you believe our 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.