CareFirst

APPEAL FORM

Account Holder Information (Please Print)			**Spending Account ID #**
			S A
Last Name	First Name	Middle Initial	**Social Security #** (if SA# is not known)
Street Address			
City	State	Zip	**Daytime Phone #**
Account Holder Email Address	Employer Name		

Relationship to member ☐ Self ☐ Other If other, indicate relationship:_____

Service Information

Date(s) of Service	Claim Number*	Type of Claim (FSA, Dep Care)	Submitted Amount of Claim	Disputed Amount

*Please attach a copy of the Explanation of Processing Report pertaining to the denial of this claim.

Please use the space provided to explain your concern. Included names and dates when possible. You may attach a separate sheet if necessary.

Authorization

I hereby authorize Further to conduct an internal review of the situation described above.

Account Holder Signature _____ Date _____

Appeal Procedures

You may appeal a denial or partial denial of your claim by following our appeal procedures. The following is a general outline of the appeal process. For specific details regarding the appeal process, please refer to your Summary Plan Description.

Level One Appeal Process:

1. Complete the Appeal form.
   To designate someone to act on your behalf complete an Authorization for Release of Information form. To obtain an Authorization for Release of Information form or to receive assistance in completing the form, please contact our customer service department at 1-866-758-6119.
2. Attach any documents, records, or other information that relates to the appeal.
3. Fax the completed Appeal form and any additional information to (866) 231-0214 or mail to:

   Further c/o CareFirst
   Attention: Appeals
   PO Box 982814
   El Paso, TX 79998-2814

A full and fair review of your appeal will be provided and a notice of the determination will be provided in writing and mailed to you within 30 days.

***PLEASE NOTE:** You have until the later of your plan's run out end date or 180 days from the date of your receipt of the adverse determination of the claim to file an appeal. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department.

Level Two Appeal Process:

Please refer to your Summary Plan Description for information on your additional appeal rights. If your Plan requires second level appeal rights directly to Further follow these instructions to file a second level appeal.

1. Complete the Level One Appeal process.
2. Within 30 days of the receipt of Further's initial appeal determination, or the later of your run out end date, send a written request to our Further Corporate Appeals Committee to reconsider the decision.
3. Attach any new additional documentation you would like considered.
4. Fax the letter and additional information to (866) 231-0214 or mail to:

   Further c/o CareFirst
   Attention: Appeals
   PO Box 982814
   El Paso, TX 79998-2814

A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.