



# Late Self-Payment Request/Appeal Form

## **PARTICIPANT INFORMATION**

Participant Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 MID # \_\_\_\_\_ Plan # \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_

## **EMPLOYER/APEAL INFORMATION**

Employer \_\_\_\_\_  
 Date of Appeal \_\_\_\_\_  
 Base Month *(based on hours/day(s) worked)* \_\_\_\_\_  
 Coverage Month/Month of Appeal \_\_\_\_\_

## **PLEASE WRITE YOUR APPEAL LETTER/EXPLANATION BELOW**

To the Appeals Subcommittee: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_

<b>For Office Use</b>	<b>TYPE</b>	<input type="checkbox"/> Self payment <input type="checkbox"/> Retiree dental/medical <input type="checkbox"/> IPNL/EDNL/D&L	<input type="checkbox"/> Employee contribution <input type="checkbox"/> DP tax payment	<input type="checkbox"/> COBRA <input type="checkbox"/> Disability
	<b>GRANT</b>	<input type="checkbox"/> First appeal in 12 months <input type="checkbox"/> Wrong address	<input type="checkbox"/> Second appeal in 12 months <input type="checkbox"/> Physical/mental incapacity	<input type="checkbox"/> Lag months <input type="checkbox"/> Away from residence
	<b>REFUSE</b>	<input type="checkbox"/> Third appeal in 12 months <input type="checkbox"/> Max eligibility	<input type="checkbox"/> Exceeds 12 month rule <input type="checkbox"/> Self-pay abuse	<input type="checkbox"/> NSF
	<b>OTHER</b>	_____		
	<b>PAYMENT</b>	<input type="checkbox"/> Check (# _____ )	<input type="checkbox"/> Money Order	<input type="checkbox"/> Credit Card