DELTA HEALTH SYSTEMS

Appeal for Benefits

Date	
Employer	
Employee Name	
Employee Health Care ID (HCID) #	
Patient Name	
Health Care Provider	
Date of Service	
Claim Number	

Reason Provided for Denial of Claim

(Check One)

☐	Services received were investigational and/or experimental in nature	☐	Provider(s) was out-of-network
		☐	Treatment not approved by the FDA
☐	The claim was not submitted on time (i.e., within the timely filing period)	☐	Services received were not medically necessary
		☐	The number of inpatient days was not authorized
☐	There is no additional allowance for an incidental procedure performed at the same time as the primary procedure.	☐	Failed to receive pre-authorization
		☐	Services were not covered under the plan
		☐	Treatment was not within the standard of care
☐	The patient was not eligible for benefits at the time services were received	☐	Services received were for an excluded, pre-existing condition
☐	Other:		

Reason(s) for Appeal

The claim is being appealed for the following reason(s): _____

_____

_____

Supporting Material

Additional Documents Enclosed: ☐ Yes; number of pages in addition to this page:_____ ☐ No

Documents Enclosed: ☐ Medical Records ☐ Physician's Statement ☐ Bill/Billing Statement

☐ Other:_____

Verification

I hereby verify that the above information is true, complete and accurate to the best of my knowledge. I understand that Delta Health Systems is the Third Party Administrator for the Health Plan and that services provided by Delta are strictly limited by the provisions contained in the Plan Booklet; the Employer determines plan exclusions and limitations.

Employee Signature:_____ Date:_____

Send this form, and any Supporting Material, to Delta health Systems: P O Box 1931, Stockton CA 95201.
If you have any questions, please call 1-800-422-6099.