Catholic Health LIFE Program
Appeal Form 1604A

Participant Name: ____________________________
Participant ID: ____________________________

Date Received: ____________________________  Time Received: ____________________________

Person Filing Appeal: ____________________________  Staff Completing Report: ____________________________

Relationship to Participant: ____________________________

How Reported: □ In Person □ Phone □ Mail □ E-Mail □

Describe your request and reason for your appeal:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

☐ I wish to request an expedited review because:

____________________________________________________________________________________________
____________________________________________________________________________________________

Signature: ____________________________  Date: ____________________________

(If received verbally, IDT member to fill in, sign, and date)

Reason for Appeal

☐ Denial or restriction (limited authorization) of service including amount, type or level of service
☐ Denial of Enrollment
☐ Decreased Center Attendance
☐ Dental
☐ Decreased Home Care
☐ Dentures
☐ Decreased Center Attendance
☐ Durable Medical Equipment
☐ Durable Medical Equipment
☐ Hearing Aide
☐ Glasses
☐ Hearing Aide
☐ Home Modification(s)
☐ Increased Center Attendance
☐ Home Modification(s)
☐ Increased Home Care
☐ Involuntary Disenrollment
☐ Increased Home Care
☐ Medical Procedure
☐ Involuntary Disenrollment
☐ Medical Supplies
☐ Nursing Facility Placement-Long Term
☐ Dental Supplies
☐ Nursing Facility Placement-Respite
☐ Dental Supplies
☐ Nursing Facility Placement-Short Term
☐ Dental Supplies
☐ Specialist Consultation or Visit
☐ Dental Supplies
☐ Surgical Procedure
☐ Dental Supplies
☐ Transportation
☐ Dental Supplies
☐ Other ____________________________

☐ Appeal Approved ☐ Appeal Denied ☐ Date of Appeal Determination: ____________________________

Resolution:

__________________________________________________________________________________________
__________________________________________________________________________________________

Date Service Provided to Participant: ____________

External Appeal Requested ☐

Participant Received Appeal Fact Sheet ☐ Yes ☐ No  Date: ____________________________

For Office Use Only:

Participant received verbal notification of decision ☐ Yes ☐ No  Date: ____________________________

Participant received written notification of receipt of appeal ☐ Yes ☐ No  Date: ____________________________

Participant received written notification of decision ☐ Yes ☐ No  Date: ____________________________

Revised 2/29/16