

MEMBER APPEAL FORM

IMPORTANT: DMBA must receive this appeal request within 12 months of the date of the initial benefit denial notice. Failure to file a timely appeal will bar you from any further review of this benefit denial under these procedures or in a court of law.

TYPE OF APPEAL (CHOOSE ONE B	ELOW)		
Medical/Dental preauthorization Medical/Dental claim	FSA Disabilit Life Savings	y Retirement	
FOR PHARMACY APPEALS: Contact Navitus	Health Solutions at 833-3	54-2226 or Navitus Medica	areRx at 866-270-3877.
FOR URGENT APPEALS			
IMPORTANT: Check here if the denied be standard appeals (generally 30 days) cou or (b) in the opinion of a physician fami managed without the care or treatment to	ld either (a) seriously jeopard iliar with the patient's condi	dize the patient's life, health,	or ability to regain maximum function,
APPEAL INFORMATION			
DMBA ID #:	_Claim/preauthorization #:		Service date(s):
Contract holder:		Patient:	
Patient address:			
Person filing the appeal:			
Signature of person filing the appeal:			_ Date:
Relationship to patient: Self Spous	e Child Other		
IMPORTANT: If you are not the patient or information on how the patient can design			er than 18, please contact DMBA for
Daytime phone:		Email:	
Tell us below why these benefits should be appreceded, or other supporting documentation, a		es and relevant documentati	on, such as a physician's letter, medical

Please send all documentation, including this form, to DMBA by mail or fax via the contact information below. You may also log into www.dmba.com and send a secure message through *My Messages*. (Be sure to attach any additional documentation.) Please keep copies of this form, your denial notice, and all documents and correspondence related to this appeal.

Please return this completed form to DMBA, P.O. Box 45530, Salt Lake City, Utah 84145-0530, or fax it to 801-578-5901. For questions, visit www.dmba.com or call us at 801-578-5600 or toll free at 800-777-3622.

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