



**PENSION TRUST FUND • WELFARE FUND • RETIREE WELFARE PLAN
VACATION SAVINGS PLAN • RETIREMENT ENHANCEMENT FUND**

6150 JOLIET ROAD, COUNTRYSIDE, IL 60525-3994 - PHONE (708) 482-7300
CLAIMS FAX (708) 482-7687 - ELIGIBILITY FAX (708) 352-3310 - PENSION FAX (708) 354-7732

JAMES M. SWEENEY, CHAIRMAN / DAVID M. SNELTEN, SECRETARY-TREASURER

**MIDWEST OPERATING ENGINEERS WELFARE FUND
APPEAL REQUEST FORM**

Member Name: _____ Medical ID#: _____

Address: _____ Date of Birth: _____

Phone number: _____ Member Status: _____ Active _____ Retiree

Patient: _____ Patient Date of Birth: _____

MCM Authorization number(s): _____

Claim number(s): _____

USE A SEPARATE SHEET OF PAPER TO COMPLETE THE FOLLOWING IF NECESSARY

What are you appealing? _____

Why are you appealing? _____

What are you expecting as the outcome of your appeal? _____

Check box here if you have attached additional information with your appeal.

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Welfare Fund, of any facts or medical records concerning the injury, illness and treatment of myself for this appeal. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient or Authorized Representative (Must be over age 18)

Date

Please review Page 2 for additional information regarding 1st and 2nd Level Appeals, as well as information on designating Midwest Operating Engineers Authorized Representatives.

updated January 2019

Authorized Representatives

- Members and adult dependents over age 18 who wish to designate an Authorized Representative to handle their appeal must contact the fund office at (708) 579-6600 to request a *Midwest Operating Engineers Authorized Representative Form* to complete.
 - Providers are not allowed to appeal unless designated as an Authorized Representative by the member and a completed *Midwest Operating Engineers Authorized Representative Form* is on file with the Fund Office.
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1ST LEVEL APPEAL INFORMATION

- 1ST Level Appeals must be received by the Fund Office within 180 days from the date of the initial denial.
 - Please review your Explanation of Benefits (EOB) for the denial date.
 - Initial appeal must be submitted by the member or patient (i.e., spouse, adult dependent over age 18), or the MOE Authorized Representative.
 - Please make sure to attach ***PHOTOCOPIES*** of any relevant information to support your appeal.
 - ***KEEP ALL OF YOUR ORIGINAL DOCUMENTATION AS THEY WILL NOT BE RETURNED TO YOU.***
 - You may include any documentation or information from your physician with your appeal.
 - Although you cannot physically appear, you will be notified by mail of the date and time of the 1st Level Appeal.
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2nd LEVEL APPEAL INFORMATION

- 2nd Level Appeals must be submitted within 30-days of the date of the notice that the initial appeal was denied.
- 2nd Level Appeals must be submitted by the member or patient (i.e., spouse, adult dependent over age 18), or the MOE Authorized Representative.
- Please attach any additional relevant information that was not heard during your 1st Level Appeal.
- Please confirm if you are requesting to appear at the 2nd Level Appeal's Meeting.
- You will be notified of the date and time to appear.
- ***DO NOT SIGN or CHECK BOXES BELOW UNLESS YOUR 1ST LEVEL APPEAL HAS BEEN DENIED***

- I, _____, would like to appear at the 2nd Level Appeal's Meeting.
- I have attached additional information that was not heard at my 1st Level Appeal's Meeting

Patient or Authorized Representative (Must be over age 18)

Date