Pequot Plus Health Benefit Services
A Division of Pequot Health Care
1 Annie George Drive
P.O. Box 3620
Mashantucket, CT 06338-3620
Tel: 888-779-6872 Fax: 860-396-6157

MASHANTUCKET PEQUOT TRIBAL NATION
FAMILY HEALTH PLAN MEDICAL AND DENTAL BENEFIT
APPEAL REQUEST FORM

Member Name: ________________________________ Member ID#: _______________

Patient: ____ DOB: _____________________

Mailing Address: _________________________________ Phone #: __________________

City: ________________________________ State: _____ Zip Code: __________________

If this appeal relates to a specific claim, please provide the provider's name and the dates of service.

Provider: _______________________________ Dates of Service: _________________

What decision are you appealing?

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Explain why you believe the service should be covered: (*Attach additional sheets, as needed)*

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Ensure to attach any supporting documentation that shows why you believe your services should be covered. These include, but are not limited to medical records, provider letter(s), brochures, notes, receipts, etc.

_____________________________________ ____________________

Member/authorized representative Signature Date