



Chicago Regional Council of Carpenters Welfare Fund

Instructions for Completing an Appeal Form

- 1. Determine if you have a claim for benefits.** Only a Participant, parent/guardian, patient, or Authorized Personal Representative has the right to appeal enrollment/eligibility for benefits or a claim for benefits that was denied in whole or in part. A claim for benefits must contain all of the following information: (a) patient's name (b) patient's date of birth, (c) Participant's name, (d) Participant's social security number or the identification number assigned by the Fund Office, (e) date of service, (f) name of the health care provider, (g) health care provider's tax identification number (h) address of health care provider, (i) procedure code and its corresponding meaning, (j) place of service, (k) the claim amount, and (l) a denial code and its corresponding meaning. A claim containing this information is called a "post service claim."

The Chicago Regional Council of Carpenters Welfare Fund does not require you to obtain prior approval (sometimes referred to as pre-authorization) for services or other medically necessary items prior to consideration of payment by the Fund (also known as a "pre-service" claim). A request (either verbally or in writing) by a provider or Participant to determine whether a certain procedure, prescription, or treatment is covered under the Plan (often referred to as a "pre-determination of benefits request") is **not considered a claim for benefits**; and therefore can not be appealed. A claim for benefits is one in which services have been rendered and the Fund has received a bill. Therefore, only a claim that has been **processed by the Fund Office and denied** (also known as a "post-service" claim), in whole or in part, can be appealed.

- 2. Determine if you are filing a timely appeal.** If a post service claim has been denied, in whole or in part, the Participant, parent/guardian, patient or Authorized Personal Representative has no more than 180 days after you receive an adverse benefit determination to file an appeal.
- 3. Complete the Appeal Form in its entirety.** Print clearly in blue or black ink and answer all questions. If the form is not legible, if a question is left unanswered or if the form is not signed, it will be returned to you for completion. An Appeal Form must be signed and dated to be valid.
- 4. Attach additional information or evidence to the Appeal Form.** You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your appeal.
- 5. Submit the completed Appeal Form and any additional information to substantiate your appeal to:**

Scan & Email: Appeals@crccbenefts.org

Fax: Chicago Regional Council of Carpenters Welfare Fund
Attn: Appeals Committee
Fax Number: 312-951-1515
(Note: Write the Participant's name and ID number on each page)

Mail: Chicago Regional Council of Carpenters Welfare Fund
Attn: Appeals Committee
12 East Erie Street 7th floor
Chicago, IL 60611

- 6. What's happens next?** Within five (5) business days of the Plan's receipt of your request for an appeal, (1) the Plan will complete a preliminary review of the request to determine whether you have an appealable claim and (2) mail a letter to you acknowledging receipt of your appeal and informing you of the date of the next appeals meeting. Properly filed appeals are reviewed at the next regularly scheduled Appeals Meeting. The Appeals Committee meets at least quarterly. You will be notified of the Trustees' decision via first class mail, five (5) business days after making their determination.

Note:

- ✓ The appeal must be submitted in writing by the Participant, parent/guardian, patient or Authorized Personal Representative, within the applicable time frame. Copies of evidence supporting the appeal can be included.
- ✓ A covered individual may designate an Authorized Personal Representative by completing an Authorized Personal Representative Designation Form and submitting it with the Appeal Form.
- ✓ Providers or suppliers of service do not have appeal rights unless a covered individual designates the provider of service as his/her Authorized Personal Representative and the Fund Office receives a completed and signed Authorized Personal Representative Designation Form or one must be on file with the Fund Office.



Service. Security. Stability.

Chicago Regional Council of Carpenters Welfare Fund

12 EAST ERIE STREET • CHICAGO, IL 60611

(312) 787-9455, OPTION 3

FAX: 312-951-1515



Appeal Form

To: The Board of Trustees - Attn: Appeals Committee

Participant's Name (the Carpenter)

Participant's ID # (located on your BCBS ID Card)

Participant's Street Address, City, State & Zip Code

Daytime Phone Number

Email Address

I am requesting an appeal of:

Enrollment or Eligibility for Benefits
Adverse Benefit Determination (complete the section below)

Claim Number(s) (on the Explanation of Benefits)

Date(s) of Service

Name of Provider(s)

Patient Name

Patient's Date of Birth

Patient's address (if same as Participant write same)

Name of Person Filing the Appeal

Daytime Phone Number

Email Address

I am the Carpenter Parent/Guardian Patient Authorized Personal Representative (if Authorized Personal Representative, the patient must complete an Authorized Personal Representative Designation form and include it with this form or one must be on file with the Fund Office.)

State the reason(s) why you believe you should be allowed to enroll in the Plan or why you believe you should have eligibility for benefits or why you disagree with the adverse benefit determination: (if more room is needed attach a sheet of paper)

Check if you are including new or additional evidence (attach to form).

**Signature of Participant, Parent/Guardian,
Patient or Authorized Personal Representative**

Date