MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

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 PRESCRIPTION DRUG PROGRAM APPEAL REQUEST FORM

Member Name: _____ MOE ID#: _____

Address: _____Date of Birth: _____

Contact number: _____ Member Status: Active _____ Retiree _____

APPEAL INFORMATION

Patient's Name: _____ Patient's Date of Birth:_____

Please provide a description of the reason for your appeal:

_____

_____

_____

_____

_____

_____

Check 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.

_____ _____

Member Signature, Patient Signature (**if over the age of 18),** or Authorized Representative Signature

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.

Authorized Representatives

- Members and adult dependents over age 18 who wish to designate an Authorized Representative to handle their appeal must contact the Pharmacy Benefit Department at (708) 387-8331 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.

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.

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

_____ _____

Member Signature, Patient Signature (**if over the age of 18**), or Authorized Representative Signature

Date