



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

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

**MIDWEST OPERATING ENGINEERS  
APPEAL REQUEST FORM**

Complete this form if you would like to request an appeal. Please include all information needed to support your appeal, such as documentation from your physician and photocopies of any relevant materials. Do not send original documents, as submitted materials will not be returned. Once completed, please return to the Fund Office as advised by staff.

**MEMBER INFORMATION**

Name: \_\_\_\_\_ MOE ID: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**APPEAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Case Manager Authorization Number(s), if applicable: \_\_\_\_\_

Claim Number(s), if applicable: \_\_\_\_\_

Please provide a detailed explanation of your appeal request, including the reason for the appeal. Providing detailed information will help ensure a thorough review:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check this box if you have attached additional information with your appeal form.

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, if required 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.

\_\_\_\_\_  
Signature (Member, Patient Over Age 18, or Authorized Personal Representative) \_\_\_\_\_ Date \_\_\_\_\_

**If you would like to request a 2<sup>nd</sup> Level Appeal, please refer to page 2.**

The information below explains how to designate an authorized representative and provides details about the 1st and 2nd Level Appeals process:

### Appeal Authorized Personal Representative

- You may choose someone age 18 or older to act on your behalf during the appeals process. This person is called an Authorized Personal Representative.
- Providers cannot appeal on your behalf unless they are designated as an Authorized Personal Representative and a completed form is on file with the Fund Office.
- To obtain an Appeal Authorized Personal Representative Form, please contact the Fund Office.

### 1<sup>st</sup> Level Appeal Information

- **Submission timeframe:** Must be submitted to the Fund Office within 180 days after you receive written notice of the denial.
  - Please review your Explanation of Benefits (EOB) for the denial date.
- **Who may submit an appeal:** The member or patient (i.e., spouse, adult dependent over age 18), or the Appeal Authorized Personal Representative.
- **Appeal documents:** Please make sure to attach photocopies of any relevant information to support your appeal.
  - Keep all of your documents as submitted materials will not be returned.
- **In-person attendance:** Attendance in person is not available. You will be notified of the appeals meeting date at which your appeal will be presented.

### 2<sup>nd</sup> Level Appeal Information — Available After First-Level Appeal Denial

- **Submission timeframe:** Must be submitted to the Fund Office within 30 days of the date of the certified notice date from when the initial appeal was denied.
- **Who may submit an appeal:** The member or patient (i.e., spouse, adult dependent over age 18), or the Appeal Authorized Personal Representative.
- **Appeal documents:** Please make sure to attach photocopies of any relevant information to support your appeal that was not included in your 1<sup>st</sup> Level Appeal.
  - Keep all of your documents as submitted materials will not be returned.
- **In-person attendance:** Attendance in person is available.

You may appear at the 2nd Level Appeal Meeting and submit new information not included in your 1st Level Appeal. If you wish to attend, you will be notified by mail of the appeals meeting date and time. Please check the box below and complete the information as applicable.

- I, \_\_\_\_\_, would like to appear at the 2<sup>nd</sup> Level Appeal's Meeting.
- I am submitting new information not included in my 1<sup>st</sup> Level Appeal.

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Signature (Member, Patient Over Age 18, or Authorized Personal Representative)

Date