Reset

PEKIN LIFE INSURANCE COMPANY
Attn: Life & Health Claim Grievance Committee
2505 Court Street • Pekin, Illinois 61558
(800)371-9622 • Fax: (309)346-8265
www.pekininsurance.com

REQUEST FOR REVIEW

Information on person filing appeal

Relationship to the Patient: ❒ Patient/Insured ❒ Parent/Legal Guardian ❒ Provider*
❒ Other* _____

*To file on the patient's behalf, you must also submit an Appointment of Authorized Representative Form (LG316) completed by the patient.

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Information about the Patient/Claim

Member ID _____
Claim Number _____
Date of Service _____ Total amount of claim _____
Member Name _____
Patient Name _____
Patient's Date of Birth _____ Patient Phone Number _____

Reason of Review Request

I am requesting a review of:

❒ A claim that was processed and coverage was denied, benefits reduced or some other issue exists with the handling of the claim.

❒ A request for preapproval of treatment that was denied and I believe the denial is incorrect.

Please provide a full detailed explanation of your reason for appeal, what you expect the outcome of the appeal to be and the basis for your appeal. You should include all supporting documentation. If we denied your claim or preapproval due to lack of medical necessity, as experimental/investigational or for lack of medical appropriateness you should also include a written statement explaining your medical situation and include all supporting medical documentation.

Signature of Person Filing Appeal _____ **Today's Date** _____