Q3 Business Technology Corp.
P. O. Box 15952
Fort Wayne, IN 46885

www.q3online.com
Phone 260.492.9979 877.251.8324
Fax 260.492.9989

MEDICAL APPEAL FORM

If you would like Q3 to reconsider our initial decision on your benefit claim, please complete this appeal form. You must write to us within 6 months of the date of our decision. You can mail or fax your request to us.

Mail your request to Q3 Business Technology Corp., P. O. Box 15952, Fort Wayne, IN 46885; or
Fax your request to the Appeals Department at (260) 492-9989

Patient name: ____
Plan ID number: ______________________
Claim Info: ____
Your name: ____
Your status: □ Covered person □ Patient □ Authorized representative
If an authorized representative, explain your relationship to the patient:
____

Your mailing address:
____
____
____

Your Phone Number: ______________________

Please explain why you believe our initial decision was wrong, based on specific benefit provisions in your plan brochure:
____
____
____
____
____

Attach additional sheets, if needed. Supporting documents may be necessary for review, such as an operative report for a review of surgery charges. Please send copies of documents that support your appeal, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms. The review may be delayed if supporting documents must be requested by us.

I confirm that the above information is correct.

______________________________ ____________
Signature Date

We require all appeals to be authorized by the patient and Plan Enrollee (employee), if different than the person/organization filing the appeal.

______________________________ ____________
Signature of Patient Date

______________________________ ____________
Signature of Enrollee Date