PHARMACY CLAIM APPEAL FORM

You are entitled to a review (appeal) of a benefit determination if you have questions or do not agree with the determination. To request a review, we recommend you submit this form along with any comments, documents, records or other information you would like to be considered. This must be done within 180 days from receipt of the original benefit determination (Explanation of Benefits). This form will help you provide us with the information needed to consider your appeal.

☐ 1st level of appeal ☐ 2nd level of appeal

If you do not agree with the 1st level appeal determination you may request a second (final) review. This review must be requested within 90 days from the date you receive notification

SUBSCRIBER/PATIENT INFORMATION	
SUBSCRIBER NAME	SUBSCRIBER SOCIAL SECURITY NUMBER (CONTRACT #)
PATIENT'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER
SUBSCRIBER HOME ADDRESS	
SUBSCRIBER HOME TELEPHONE NUMBER ( )	
SUBSCRIBER WORK TELEPHONE NUMBER ( )	
CLAIM INFORMATION	
NAME OF PROVIDER(S) WHOSE BILL IS IN DISPUTE	
DATE(S) OF SERVICE	

Important Note
To expedite the review of your appeal please provide a copy of the Explanation of Benefits for the claim(s) in dispute. Additional information may be necessary to provide a thorough review. You **must** include any and all documentation you would like to be considered with your appeal.

SUBMIT THIS FORM AND ANY ADDITIONAL INFORMATON TO:

Publix Group Benefits Department
Attention: Health Benefits Coordinator
P. O. Box 32040
Lakeland, FL 33802-2040
Fax: 863-284-3300

Should you need more claim appeal forms, call the
Group Benefits Department at
1-863-688-7407, ext. 52280 or
Toll-free 1-800-741-4332 (outside of Lakeland)

PHARMACY CLAIM APPEAL FORM

(continued)

Please describe the nature of your appeal request and any facts you feel should be considered in the appeal process. Use additional sheets as necessary. Please staple to this form: a copy of the bill(s) in dispute, the Explanation of Benefits or notice of non-payment, medical records, if applicable, or any additional documentation which is part of your appeal request.

I hereby request an appeal of the claim determination described above. I have contacted OptumRx concerning this matter and I do not agree with the determination. I understand that receipt of this Pharmacy Claim Appeal Form by the Publix Group Benefits Department initiates the "Review of Claims" process. I also understand that if my first appeal request is not resolved to my satisfaction, I may then file a second (final) appeal with Publix's Group Health Benefit Committee by submitting a second Pharmacy Claim Appeal Form to the Publix Group Benefits Department.

Date: _____ **Signed:** _____

Publix Authorization Form for Appeals by Personal Representative

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

Pursuant to the *Review of Claims* subsection of the *Claims Processing* section of the PPO Member Handbook ("Handbook") for the Publix Super Markets, Inc. Group Health Benefit Plan (the "Plan"), a Plan Member must act on his/her own behalf if he/she wants to exercise his/her rights under this plan. To authorize a representative to act on his/her behalf, a Member must complete, sign, date and submit this authorization form for review of a denied claim. If a Plan Member authorizes a representative to act on his/her behalf, the Member will not be afforded the right to appeal a claim on his/her own behalf, but will instead be delegating that right to the authorized representative.

If both the front and back sides of this form are not fully completed, Publix will be unable to process your request.

Please print your responses.

1. Publix Associate/Subscriber Information

Last Name		First Name	Middle Initial
Publix Personnel Number	Social Security Number	Birth Date (MM/DD/YYYY)	Telephone Number ( ) -
Street Address		City, State and ZIP Code	

2. Plan Member Information (Individual who is authorizing a personal representative)

Last Name		First Name	Middle Initial
Subscriber ID number (from OptumRx ID Card)	Social Security Number	Birth Date (MM/DD/YYYY)	Telephone Number ( ) -
Street Address		City, State and ZIP Code	
Provider			

3. Authorized Personal Representative

I authorize the following person or entity to submit an appeal to the Plan, and assume my appeal rights under the Plan for the above medication in question. This authorized personal representative is also authorized to receive records and healthcare information regarding my appeal of the above medication in question. If any costs or fees are associated with providing the authorized person or entity with the requested documentation, I agree to be responsible for the payment of such cost or fees.

Individual or Company authorized to submit an appeal	Telephone Number (including area code)
Street Address	City, State and ZIP Code

This authorization will remain valid until the first of the following events occurs:

- The appeal process for the medication in question is completed;
- You tell us in writing the authorization is void or revoked; or
- The expiration of 24 months from the date of your signature.

4. ACKNOWLEDGMENT: Your signature below means that you understand and agree to the following:

- Information disclosed as permitted by this authorization may include my protected health information which may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.
- My ability to enroll in a Publix Group Health Benefit Plan (the "Plan"), and my eligibility for benefits and payment for services, will not be affected if I do not sign this form. However, without my witnessed signature, my request to authorize the person or entity named in Section 3 above will not be completed.
- All terms, conditions and administrative processes and provisions of the Plan, including but not limited to the *Assignment and Attachment* subsection of the *General Provisions* section of the Handbook, are still in full force and effect.
- I must complete a HIPAA Authorization Form from Publix Super Markets and return it with this form; unless I am the member's treating health care provider and affirm I/we already have a HIPPA authorization on file.
- I understand that if any information on this authorization form or the HIPAA Authorization form is incomplete or incorrect that this form will not be processed.

_____ _____

Member Signature Date

_____ _____

Witness Signature Date

Return this completed form and relevant documentation, if required,
to: Publix Group Benefits Department
Attention: Health Benefits Coordinator
P.O. Box 32040
Lakeland, FL 33802-2040
Fax: 863-284-3300