Davis Vision
Complaints and Appeals
PO Box 547
Troy, NY 12181

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal an adverse determination.

Insured Member's Name _____ Member ID _____
Email _____ Phone _____
Mailing Address _____
City_____ State _____ Zip Code _____
Name of Treating Provider _____

(If applicable) Authorized Representative Name_____
Email_____ Phone _____
Mailing Address_____
City_____ State_____ Zip Code_____

Type of Denial: _____ Denied Claim _____Denied Service Not Yet Received

Name of Insurer_____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30-day delay in receiving the service likely cause a significant negative change in your condition? If "Yes," your treating provider must sign and send a certification and documentation supporting the need for an expedited review.

What decision are you appealing? _____
_____
_____
(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered. _____
_____
_____
_____
_____
_____
_____
_____
(Attach additional sheets of paper, if needed.)

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: ☐ Medical records ☐ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) If you are seeking expedited review, also attach the certification and supporting documentation from your treating provider. If you have questions about the appeals process or need help to prepare your appeal, you may call the Arizona Department of Insurance and Financial Institutions Consumer Services number (602) 364-2499, or Davis Vision Customer Service at 800-999-5437.

_____ _____
Signature of Insured Member or Authorized Representative Date