

IHN APPEAL REQUEST

Complete and mail signed form in enclosed prepaid envelope.

1. MEMBER INFORMATION (PLEASE PRINT)

IHN Member Name: _____ Member ID# _____

2. APPEAL INFORMATION

I would like to appeal (what was denied):

The reason(s) I think the decision should be changed (is)are:

3. Be sure and read the "Continuing your benefit" information on the "How to file an Appeal" instruction sheet before checking this box.

I want to continue my benefits during the Appeal process.

4. Request For Expedited (fast) Appeal- Check the box below if it applies to your medical condition.

The regular time frame of 16 days to process the appeal could put my life in danger.

5. YOUR SIGNATURE

You must sign and date this request. When a child is a minor wanting to appeal, their legal guardian must sign. **If this form is not signed, IHN will not process your appeal.**

Signature: _____ Today's Date: _____

Relationship to Member: _____