MCA Administrators, Inc.

Request for Review of Benefit Denial

Important Notice: This request for review must be received by the Plan within 180 days of the date of the Notice of Benefit Denial. Failure to file a timely appeal will bar you from any further review of this benefit denial under these procedures or in a court of law. Be certain to keep copies of this form, your denial notice and all documents and correspondence related to this claim.

Person Filing this Appeal: *(check one)* ☐ Employee, ☐ Patient, ☐ Authorized Representative (If Authorized Representative, the claimant must complete attached **Appointment of Authorized Representative** form.)

Employee Name:	Member ID:
Address:	Claimant Name:
City:	Group Name:
State:	Group Number:
Zip Code:	Phone Number:

Authorized Representative:	Relationship:
Address:	Phone Number:
City:	
State:	
Zip Code:	

Date of Notice of Benefit Denial:	Claim/Case Number:
Provider Name:	Date of Service:

Describe the reasons why this benefit denial should be changed on appeal. (Attach additional pages and relevant documentation, as necessary.)

_____

_____

_____

_____

Signature_____ Date_____

Submit this Request Form with all supporting documentation by mail to:

MCA Administrators, Inc.
Attn: Appeals Department
Manor Oak Two
1910 Cochran Road, #605
Pittsburgh, PA 15220

Or **fax** all supporting documentation to: 1-412-202-5763

IMPORTANT: If this is an urgent care appeal, as defined by law, you may submit the information contained in this Request for Review Benefit Denial form by contacting MCA Administrators, Inc. at 1-800-922-4966 or via fax at 1-412-202-5763.

MCA Administrators, Inc.

Appointment of Authorized Representative

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representation)* Date

**(Parent, Guardian, Conservator or Other – Please Specify)*

_____

Print Name

Address of Authorized Representative: _____

_____

Daytime Phone: _____ Evening Phone: _____