



## EMI Health Customer Relations Appeal Form

5101 S Commerce Drive • Murray, Utah 84107 • 801-262-7475 • 800-662-5851 • www.emihealth.com

Insured's Name	Member ID Number
Current Address	
City	State      Zip
Employer	Physician
Patient's Name	Date(s) of Service

**1. EXPLANATION OF APPEAL:**

**2. WHAT WRITTEN AND/OR ORAL COMMUNICATION HAVE YOU RECEIVED? FROM WHOM?**

**3. EXTENUATING CIRCUMSTANCES OR ADDITIONAL INFORMATION:**

**4. WHAT IS YOUR EXPECTATION FOR RESOLUTION?**

Please attach copies of any supporting documents (referrals, claims itemized bills, and letters from doctors, etc.) EMI HEALTH IS AUTHORIZED TO INVESTIGATE MY APPEAL. I UNDERSTAND THAT THIS MAY NECESSITATE A REVIEW OF THE MEDICAL AND FINANCIAL RECORDS RELATING TO MY HEALTH.

Signature - insured or patient \_\_\_\_\_ Date \_\_\_\_\_