Claim Appeal Form

This form can be submitted electronically from your My EMI Health online account at https://emihealth.com/Identity/Account/login, sent via email to claimsreview@emihealth.com, or mailed to EMI Health - PO Box 21482 Eagan, MN 55121. Questions, please call customer support at (800) 662-5851, Monday-Friday 6:00 am -6:00 pm (MT).

Insured's Name	Member ID Number
Current Address	
City State Zip	Plan
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