



Member Complaint and Appeal Form

NOTE: Completion of this form is voluntary. To obtain a review, you or your authorized representative may also call our Member Services Department using the telephone number displayed on the member ID card or submit a request in writing to the address listed at the end of your Explanation of Benefits (EOB) or other correspondence received from us.

Please provide the following information for the primary Insured/Member.
(This information may be found on the front of your ID card.)

Today's Date	Member's ID Number	Plan Type <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Member's Group Number (Optional)
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Member's First Name	Member's Last Name	Member's Birthdate (MM/DD/YYYY)
Member's E-mail Address		

Please provide the following information for the person you are submitting the request for.

First Name	Last Name	Birthdate (MM/DD/YYYY)
Relationship to person requesting the appeal: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
Note: If your selection is spouse, child (18 years of age or older) or other, please submit a completed an Authorized Representative Form with your request. The form can be found on mhbppostal.com/plan-documents/		
Please advise if the appeal is related to: <input type="checkbox"/> Pre-Service <input type="checkbox"/> Post Service		

To help us review and respond to your request, please provide the following information.
(This information may be found on correspondence from us.)

Claim ID Number (If Post Service selected above.)	Reference Number (If Pre-Service selected above.)	Service Date (If Post Service insert date of services, if Pre-Service insert date of denial.)
Explanation of Your Request (Please use additional pages if necessary.)		
Member's Signature		

Note: When submitting this form with your request please include: - Bills and/or correspondence for these services.
- Any other helpful information.

You may mail your request to: **MHBP Postal Service Benefits Plan**
PO Box 981106
El Paso, TX 79998-1106

Or use our National Fax Number: 859-455-8650

