WorldTrips
PO Box 241778
Apple Valley, MN 55124
800-605-2282 / 1-317-262-2132

Claimant Appeal Request Form

You may use this form to appeal a coverage decision or you may request an appeal by following the appeal procedure outlined in your policy documents.

PLEASE PRINT

Insured Name:	Claimant (Patient) Name:
Mailing Address (Include Street Address, City, State, Country, and Postal Code):	Policy/Certificate #:
	Primary Phone:
	Work Phone:
	Home Country:
Authorized Representative*:	Email Address:
Service or Claim That Was Denied:	Date of Service (mm/dd/yyyy):
Provider Name:	Claim #(s):
Please explain your appeal and your expected resolution. (You may attach extra pages if you need more space.) PLEASE ATTACH ANY DOCUMENTS OR MEDICAL RECORDS THAT YOU BELIEVE SUPPORT YOUR APPEAL.	

_____ _____
Member (or Representative) Signature Date

_____
Relationship to Member (if Representative)

IMPORTANT: If you are not completing and submitting this form online via Member Portal, you must send the completed form to the following mailing address or email address for resolution of your request.

Mail to: WorldTrips Appeals PO Box 241778 Apple Valley, MN 55124 U.S.A	OR	**Email to**: appeals@worldtrips.com

**If you are requesting that a third party handle your appeal on your behalf, please complete an "Authorization Form for Use and/ or Disclosure of Protected Health Information" form. You may fill out and submit the form online via the Claims and Appeals page in Member Portal. OR you may visit http : / / worldtrips . com / downloads to download a PDF of the form.*