LEVEL II APPEAL PROCEDURE

If you are not satisfied with the Level I decision, you have the right to ask the Fund's Level II Claim Appeal Committee to review your claim. If you would like the Committee to review your case please complete and return this form, within 30 days of your Level I denial, to the following address:

Level II Claim Appeal Committee
Central States, Southeast and Southwest Areas
Health and Welfare Fund
P. O. Box 5111
Des Plaines, Illinois 60017-5111
(847) 518-9800

*** Please be sure to attach a copy of our Level I denial letter to this form when submitting.**

_____ Member's Name	☐☐☐ - ☐☐ - ☐☐☐☐ Social Security Number
_____ Address	_____ Claim Number(s)
_____ City, State, Zip	_____ Patient's Name
( ) _____ Phone Number	_____ Claimant's Name

Issue to be reviewed:

_____

_____

Please present your reason for disagreement with the Level I decision and what action you feel should be taken (use additional sheets if necessary):

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_____ Member's Signature

_____ Date