UCSF Health Insurance Denied Waiver Appeal Form

Academic Year 2018-2019

IMPORTANT: Please read the following to ensure you are eligible for this appeal.

- Your appeal must be submitted within **ten (10) business days** of the date of notice of denial. Appeals received after the ten (10) day grace period will not be considered.
- Appeals will ONLY be considered for the current term. Waivers granted on appeal will NOT be applied to any previous school term.
- Evaluation of your appeal will be based on University Health Insurance comparability guidelines in effect at the time of the original waiver application.

INSTRUCTIONS FOR THE APPEAL

(You will be notified of the status of your appeal within ten (10) business days after receipt of your complete appeal)

NOTE: Complete Sections A, B, and C. Appeal forms that are incomplete will not be considered for evaluation.

Section A (Student Information)

Last Name	First Name	MI	UCID	DOB

Current Address	City	State	Zip

Telephone Number	Email

Academic Program/Level

Term of Appeal (Check only one of the boxes)

☐ **Fall Quarter 2018** ☐ **Winter Quarter 2019** ☐ **Spring Quarter 2019** ☐ **Summer Quarter 2019**

Signature	**Date**

Section B (Insurance Information)

Insurance Company:_____ Insurance Company Phone#:_____

Member ID Number**:**_____ **Please attach a copy of your insurance member ID Card**

Section C *(Please provide the correct answer to the question(s) that denied your waiver. Please provide details you feel are important to consider in reviewing your appeal.)*

(Please add additional pages as necessary)

OFFICIAL USE ONLY		
Appeal is Incomplete ☐	**Appeal is Denied** ☐	**Appeal is Approved** ☐
Student Emailed? Yes No	**Student Emailed? Yes No**	**Approval done in WF site? Yes No**
Appeal Evaluator Signature		Date

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