If you disagree with the processing of your claim or Adverse Benefit Determination, you may file an appeal using this form.

Appeal Filing Form

CONCIERGE
Third Party Administrator

Date: _____

Employee ID: _____ *Required (ID Number that appears on ID Card)*

Employee Name: _____

Patient Name: _____ Member Phone #: _____

Claim #: _____ *(as it appears on EOB)*

Date of Services: _____

Provider Name: _____

Servicing Address: _____ City: _____ State: _____

Type of Services or Procedure: _____

URGENT: ☐ Yes ☐ No

Concierge, PO Box 4070, Bartlesville, OK 74006
ATTN: Legal Department / Appeal
Fax: 918.333.9505

Name of person filing appeal: _____

Indicate if: ☐ Covered Person
☐ Authorized Representative
Address of Authorized Representative:

_____