Claim Appeal Form

Use this form to request an appeal of a previously denied reimbursement request.

INSTRUCTIONS

1. **Fill** in all requested information and **attach** all supporting documentation if applicable.
2. **Submit** this completed form to Igoe Administrative Services for review via:
   - Email to claims@goigoe.com.
   - Fax to 800-456-9083.
   - Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480.
3. **Tips**
   - Appeals are reviewed by the Appeals Committee designated by the Plan Sponsor
   - Please allow up to 60 days for the Appeal to be reviewed and the subsequent decision to be communicated
   - **Please note**: All appeals must be received within 180 days of the claim denial.
   - Please attach the original claim and all supporting documentation. You may attach additional documentation outlining why you are requesting an Appeal if the Description of Appeal section is not large enough.
4. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You (All information is REQUIRED. Please print clearly)

Employer Name			
Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Appeal Information

(Clear Expense List)

Claim Dates	Description of Appeal Reason	Net Amount
-		$
-		$
-		$
-		$
-		$
	Total Expenses $	0.00

Section C: Authorization REQUIRED (PLEASE SIGN AND DATE)

I certify that I am a participant in the plan from which I am requesting reimbursement and that all expenses listed with this claim were incurred during my active participation in said plan. I certify that these expenses have not been and will not be reimbursed under any other benefit plan or charged to my employer's Benefits Card (if applicable). I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information herein. I further acknowledge that each expense listed above must be a proper expense under the Plan. If not, I understand that I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE. If understand that appeals are reviewed by the Appeal Committee established by the Plan Sponsor in accordance with the appeals process outlined in the Summary Plan Description.

Signature: Ready To Sign? Click To Print _____ ***Date:*** _____

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