MEDICAL BENEFITS CLAIM APPEAL
FIRST LEVEL FORM
PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

If you are not satisfied with the disposition of a claim, you or your representative may make a written Request for Reconsideration using this approved form. Please complete this form and mail within one hundred eighty (180) days with all documentation not previously provided that may support your claim to: **UMR; Attn: PBC Firefighters Employees' Benefits Fund Claims Appeal, PO Box 30546 Salt Lake City UT, 84130-0546**. UMR, will make a decision within sixty (60) days of receiving this Request and will notify you in writing with the specific reasons for the decision. If, after completion of this initial review, your claim remains denied in whole or in part, you or your representative have the right to submit an appeal in accordance with the Claim Review Procedure of your Plan Document using the approved "Second Level Claim Appeal Form" contained in your Plan Document.

Please Print Employee Name:
Name of Patient (if different):
ID Number:
Date of Illness or Injury:
Nature of Illness or Injury:
Please explain why this claim should be reconsidered (attach additional sheets if necessary):

_____ _____

Signature of person requesting reconsideration Date

(Revised: 06/2023)