Intake #: _____

UNFAIR / UNEXPLAINED DENIAL OF CLAIMS

NEW INQUIRY

Date: _____ E-mail: _____

Name: _____

Address: _____

Home Phone No.: _____ Cell Phone No: _____

Are you currently insured? Yes ☐ No ☐

Do you currently suffer from a chronic condition for which you receive treatment?

Yes ☐ No ☐

Has your provider rejected your claim for benefits in relation to treatment for a chronic condition?

Yes ☐ No ☐

Had you previously been insured by another insurance company?

Yes ☐ No ☐ If yes, please specify which insurance company. _____

Did that insurance company cover a benefit that has since been denied?

Yes ☐ No ☐

Explain any facts specific to your health benefits claim and subsequent denial:

*PLEASE RETAIN ANY LETTERS RECEIVED FROM PROVIDER.

Fax this form to Clifford Law Offices at 312-251-1160 or scan and e-mail to ClaimDenial@cliffordlaw.com.

Print