Appeal of Declined Coverage

Applicant Name: ____________________________ Farm Bureau Membership Number: ______________________

Applicant Address: ____

Applicant City, State, Zip Code: ____

This form must be completed by the applicant who was declined coverage, or by the primary applicant on behalf of dependents under the age of 18. If you have an Authorized Personal Representative designated (with the form on file), you may have them appeal this decision for you.

This appeal is from:

☐ Applicant

☐ Applicant on behalf of a child. Dependent Name: ____

☐ Authorized Personal Representative. Applicant Name: ____________________________________

Is this an:

☐ Initial Appeal

☐ Secondary Appeal (appeal of initial appeal decision)

Please provide detailed information concerning the reason you are appealing the decision:

____

____

____

____

____

You may also attach pertinent documents, including medical records, pharmacy records, and any other information you would like considered in this appeal.

Please send this form along with any documentation to the address below:

Farm Bureau Health Benefit Plan, LLC
Attention: Appeals
PO Box 9168
Des Moines, IA 50316

Signature: ____ Date: ____________________________

NOTE: If you are requesting an appeal on behalf of a member or applicant, a Personal Representative Appointment form must be submitted with this form, or be on file with Wellmark Administrators, Inc. The form may be found at www.iowafbhealthplan.com.