Indiana Farm Bureau®
Health Plans

Request for Reconsideration of Declined Coverage

Member Name: _____ **ID Number:** _____

I wish to submit the following request for the Indiana Farm Bureau Health Plans Underwriting Department to reconsider the decision of declined coverage:

☐ Member Rejection

☐ Dependent (Child or Spouse) Rejection. Dependent Name: _____

Please provide detailed information for the reason you are requesting this reconsideration:

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Please read carefully and note the following:

- This information submitted may result in the Indiana Farm Bureau Health Plans Medical Underwriting Department requesting additional medical information. Obtaining this information and any expenses incurred will be your responsibility.
- Claims experience may be used in the reconsideration process. If the factors in your original declined coverage decision are resolved in your favor, please know that symptoms, treatments, and/or claims experience for other medical conditions discovered during this review may cause you to remain declined.

You may also attach pertinent documents including medical records, pharmacy records, and any other information you would like considered during the reconsideration process.

Please send this form along with any documentation to:

Email: underwritingforms@fbhealthservices.com | Fax: 931-560-4304

I understand the information in this request for reconsideration and any information obtained with this authorization will be used by Indiana Farm Bureau Health Plans to determine the outcome of this reconsideration. I declare that the foregoing statements provided by me on this request in its entirety are true, correct and complete for myself, my spouse, and all dependent children.

Member Signature: _____ Spouse Signature: _____ Date: _____