Retroactive Referral Appeal Request Form

Student Health Insurance Office
501 Student Health
Irvine, CA 92697-5200

Phone: (949) 824-2388
Fax: (949) 824-5062
Web: www.shc.uci.edu

Instructions:

1. **Complete** Sections A, B, C, and D; **and attach medical records.**
2. **Keep** a copy of the completed form as your receipt.
3. **Mail, fax, submit via patient portal (preferred) or drop off** the completed appeal form to the Student Health Insurance Office.
4. You will be notified of the status of your appeal within ten (10) business days after receipt of your complete appeal.

Section A: Student Information

SID Number ______ Email Address ______

Last Name ______ First Name ______ Middle I. ______ Date of Birth ______

Permanent Address ______ City ______

State ______ Zip code ______ Telephone Number ______

Section B: Outside Provider Information:

Date Seen: ______

Reason for Visit: ______

Provider Name/ Specialty: ______

Provider Address: ______

Provider Phone #: ______ Provider Fax#: ______

Section C: Reason for Appeal for Retroactive Referral

Please describe the services you obtained and what efforts you made to receive assistance at the Student Health Center prior to your off campus services (attach additional pages as needed).

Section D: Certification

Student Signature (Parent or Guardian if student is minor) ______ Date ______

For Office Use Only

Date Received	Reviewed By	Approved ( )	Denied ( )
Comments			