

# Claimant Appeal Request Form

You may use this form to appeal a coverage decision or you may request an appeal by following the appeal procedure outlined in your policy documents.

**PLEASE PRINT**

Insured Name:	Claimant (Patient) Name:
Mailing Address (Include Street Address, City, State, Country, and Postal Code):	Policy/Certificate #:
	Primary Phone:
	Work Phone:
	Home Country:
Authorized Representative*:	Email Address:
Service or Claim That Was Denied:	Date of Service (mm/dd/yyyy):
Provider Name:	Claim #(s):
Please explain your appeal and your expected resolution. (You may attach extra pages if you need more space.) PLEASE ATTACH ANY DOCUMENTS OR MEDICAL RECORDS THAT YOU BELIEVE SUPPORT YOUR APPEAL.	

\_\_\_\_\_  
Member (or Representative) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Member (if Representative)

**IMPORTANT:** If you are not completing and submitting this form online via [Member Portal](#), you must send the completed form to the following mailing address or email address for resolution of your request.

**Mail to:**

WorldTrips Appeals  
PO Box 241778  
Apple Valley, MN 55124  
U.S.A

OR

**Email to:**

[appeals@worldtrips.com](mailto:appeals@worldtrips.com)

*\*If you are requesting that a third party handle your appeal on your behalf, please complete an "Authorization Form for Use and/or Disclosure of Protected Health Information" form. You may fill out and submit the form online via the Claims and Appeals page in [Member Portal](#). OR you may visit <http://worldtrips.com/downloads> to download a PDF of the form.*