Appeal Request Form

Only ARBenefits members may file an appeal to the Employee Benefits Division (EBD).

*The following drug categories are **excluded** from coverage. EBD will **NOT** review any appeal for exluded categories, and this serves as notice of denial and response in said cases. There will be no further correspondense.*

· Weight-Loss	*· Over-the-Counter (OTC)*	*· Gender Dysphoria*
· Anti-Wrinkle Agents	*· Hair Growth Stimulants*	*· Infertility or Abortifacient*

Member Information

First Name		Last Name		
Member ID or Social Security Number	Phone Number		Date of Birth	
Street Address	City	State	Zip Code	

Authorized Representative if not member

*If you are requesting an appeal on behalf of the member, an **Authorization to Release Form** must be completed and either be submitted with this form or on file with ARBenefits. ****Providers are not to submit appeals*****

First Name	Last Name		Phone Number
Street Address	City	State	Zip Code

Medication Information

Only fill out this section if you are making a pharmacy appeal.

Medication		Currently taking? Yes No	If yes, date started:	Quantity
Dosing Schedule	Strength of Medication	Diagnosis		

Appeals MUST Include:

- This completed form
- Letter describing the reason for your appeal.
- Additional supporting documentation from your physician.

Keep copies of this form, your denial notice, and ALL documents and correspondence related to this claim.

Member Signature: ______________________________ Date:____________

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Shared Administrative Services - Employee Benefits Division
ATTN: Appeals Department - PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-6516

Rev. 8/1/2025