Member Appeal
2nd Level Request

Member Information

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

Requester Information

*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***

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

Second Level Appeals MUST Also Include:

- A copy of this form
- Letter describing the reason for your second appeal.
- ***NEW*** Documentation such as bills, medical records, or other documentation.

Keep copies of this form, your denial, and all documents and correspondence related to this Appeal.

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