OTIP RAEO

Appeal Form – Health, Dental & Life Claims

Plan Member Information

Plan Member Name ***(First, Middle Initial and Last)***	
Telephone	
Email	
Plan Sponsor	
Plan Number/Health & Dental Policy Number	
OTIP ID Number	
Claimant/Patient's Name (If not member)	
Relationship to Member	

Appeal Information

Date of Claim ***(mm/dd/yyyy)***	
Total Claim Amount	$
Why are you appealing?	

By submitting an appeal, you consent to the collection, use and disclosure of your personal information for the purposes of investigating your claim and plan administration ("Purposes"). As part of the appeal process, your information may be shared with OTIP, the insurer, your plan sponsor and medical/health professionals for the Purposes.

To support your appeal, please provide the following information:	**Forward this form and any supporting information to OTIP Benefits Services by:**
• Copy of original claim form and receipts • Original physician's referral for product or service (if applicable) • Letter of appeal from physician and/or dentist (if applicable)	• Fax: 1-866-404-6847 • Email: benefitsspecialists@otip.com • Mail: OTIP, 125 Northfield Drive West PO Box 218, Waterloo ON N2J 3Z9