2019-2020 HEALTH FEE WAIVER APPEAL

STUDENT: COMPLETE THIS FORM TO SUBMIT A WAIVER APPEAL

STUDENT NAME:_____ **PID:**_____

DOB:_____ **CONTACT PH #:**_____ **DATE:**_____

☐ **Fed/State/Covered Ca** ☐ **Medicare** ☐ **Military/TriCare** ☐ **Employee Plan**

☐ **Medi-Cal**

Location of Primary Care: _____

☐ **Group Health** ☐ **Individual** ☐ **International**

***Please provide information to support your request for APPEAL. A decision will be made in 5 business days.**

COMMENTS: _____

Please attach any information you feel is important for your waiver appeal request.

DECISION:	☐ APPROVED	☐ DENIED	☐ EMAIL SENT
UPDATES:	☐ ICE LOG	☐ WAIVER CHANGES	☐ EPIC
	☐ CONTAUTH/OVR	☐ RAFT PERSDATA	☐ RAFT CHARGE
	☐ AHP WEBSITE UPDATED		

COORDINATOR: _____ DATE:_____