Syracuse City School District
Syracuse, New York

BENEFIT APPEAL FORM

➡ SECOND STEP ⬅

INSTRUCTIONS:

This form is to be used ONLY if you have previously submitted an appeal and have received a denial and wish to appeal the decision to the Syracuse City School District Appeal Committee.

1. All appeals must be received within 60 days from the date you received your First Step decision or denial.
2. Please complete and sign the Appeal Form below.
3 Make a copy of all appeal documentation, including previously submitted physician statement(s), for your records prior to sending the appeal to the appropriate address.

Send all second step appeals to:
Syracuse City School District
Office of Human Resources
Attn: Benefit Appeals
725 Harrison St
Syracuse, NY 13210

Type of Claim *(circle one)*: **Health** **Dental** **Vision** **Prescription**

Employee Name: ______________________

Employee ID/Member ID ______________________

Name of Patient: ______________________

Name of Doctor and/or Provider: ______________________

Date(s) of Service: ______________________

Claim Number: ______________________

Is additional documentation attached? *(Circle One)* **YES** **NO**

Reason For Your Appeal *(please attach separate sheet, if necessary)*: ______________________

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Print or Type Name

____
Signature of Patient or Authorized Person

____
If not patient, state relationship to patient

____
Date

Syracuse City School District
Syracuse, New York

Revised November 2018