BeniComp Participant Appeal Form

Appeal Forms must be received by BeniComp within thirty (30) days from the date that your IncentiCare Health Screening results were released online. Your appeal will be evaluated by a member of BeniComp's Preventive Health Management (PHM) team and you will be notified of its approval. Please allow 7 days for the processing of your appeal.

A Fill in your contact information.

First Name _____ Last Name _____

Date of Birth _____ Employer Name _____

Street Address _____ City _____ State _____ Zip Code _____

B

- **If you are appealing a result(s) because it is inaccurate, complete the table below.** Place a check mark next to the test name in column 1. Your healthcare provider must complete columns 3 and 4.
- **If you are appealing a result(s) because your company's target goal is unreasonably difficult to achieve due to a medical condition** skip this section and move on to section C (on reverse side).

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4
Test Name	Appeal Requirement	TO BE FILLED OUT BY HEALTHCARE PROVIDER	
		New Test Result	Provider Signature
☐ **Body Mass Index (BMI)**	An individual may be re-tested by their physician or nurse. Height and weight must be measured without shoes.		
☐ **Blood Pressure**	An individual may either (1) be re-tested by their physician or nurse OR (2) provide 1 reading taken within the last ninety (90) days by their physician or nurse.		
☐ **Blood Glucose**	Glucose must be re-tested by a certified laboratory. Must be a 12-hour fasting glucose test.		
☐ **Cotinine**	A disputed positive lab result may be re-tested by a certified laboratory. Blood or urine-based nicotine tests will be accepted.		
☐ **LDL Cholesterol**	LDL Cholesterol must be re-tested by a certified laboratory.		

Upload your appeals form through your secure online portal

Questions about IncentiCare?
Call our Client Concierge today at (866) 222-0102.

BENICOMP INSURANCE COMPANY

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C **If you are appealing a test result because it is unreasonably difficult or medically inadvisable for you to attempt to achieve your company's goal target(s) complete the table below.** Place a check mark next to the test name(s) that you are appealing. Please have your Healthcare Provider explain how your medical condition interferes with your ability to meet the company goal(s) under Provider Notes.

Test Name	Provider Notes
☐ **Body Mass Index (BMI)**	
☐ **Blood Pressure**	
☐ **Blood Glucose**	
☐ **Cotinine**	
☐ **LDL Cholesterol**	

D Healthcare Provider's signed agreement

Healthcare Provider Statement: I have read this participant's biometric screening results and agree that attempting to achieve the goals indicated would be unreasonably difficult due to a medical condition or medically inadvisable for them to attempt.

Provider Name _____ Provider Signature _____

Date _____ Phone Number_____ Tax ID_____

E Participant's signed agreement

By signing, I verify that the information supplied by myself or my representative here is true and complete. I also understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files, a statement of claim, or an application containing any false, incomplete, or misleading information will be subject to criminal penalties applicable to state laws.

Printed Full Name _____ Signature _____ Date _____

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