MedCA APPEAL FORM

Fill in the information below using the address to which you would like the determination sent.

Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Please detail the reason(s) why you are requesting this appeal. You may attach any supporting documentation, such as a physician's letter or additional information if necessary.

_____

_____

_____

_____

I certify that, to the best of my knowledge, all the information I am submitting is true.

_____ ____/____/____

Signature **Date**

This form must be notarized.

_____

Witness

Submit the completed form and any additional information via US postal mail, email or fax to:

MedCA
376 S. Bayview Ave.
Freeport, NY 11520
Email: info@medcainc.com
Phone: 516 868 6800 Fax: 516 442 3222