Financial Assistance Appeal Form

Name: _____

Current Address: _____

Patient Identifier Number from the Notice: _____

If you disagree with the eligibility determination stated on the Harris Health System Notice you received, please complete this appeal form and mail within 65 calendar days from the date of your notice to:

Eligibility Appeals Committee
Harris Health System
P.O. Box 300488
Houston, TX 77230

We will contact you by mail within ten (10) calendar days after receiving your appeal form.

I am appealing because: _____

_____

_____

_____

_____

Signature: _____Date:_____