CalPERS

The CalPERS Long-Term Care Program

Notice of Appeal
CalPERS Long-Term Care Program (Program)

Use this form to file an appeal to the Program. Attach any documents or correspondence that should be considered in your appeal. Please refer to your Evidence of Coverage or to the letter accompanying this form for information on the appeal process.

CalPERS LTC Coverage ID: 41-_____

Please print or type clearly, fill out this form completely, and attach all appropriate documents.

Personal Information:			
Last name	**First name**	**Middle Initial**	**Phone number ( )**
Address	**City**	**State**	**ZIP code**

Representative's Information (if someone is representing you on this issue):			
Last name	**First name**	**Middle Initial**	**Phone number ( )**
Address	**City**	**State**	**ZIP code**

Appeal Information:
What action by the Program do you want to appeal? ***(Please use a separate sheet of paper if you need more space.)***
Date of Program's decision with which you disagree. __/__/_____ ***(mm/dd/yyyy)***
Why do you believe you were denied?
☐ I have attached additional documents, listed below: (for example, medical records)
Signature of Claimant or Legal Representative ***Date***

Mail or fax completed Notice of Appeal form and attachments to:

CalPERS Long-Term Care Program
PO Box 64902
St. Paul, MN 55164-0902
Fax: (866) 294-6967