



**SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND
PENSIONERS & SURVIVING SPOUSES HEALTH FUND**

501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 385-2767 | www.scptac.org | info@scptac.org

APPEAL FORM

PART 1 – PARTICIPANT INFORMATION

Name

Social Security Number (only last four digits required)

OR

IPE T50
Blue Shield ID Number

Address

Phone number

Email Address

PART 2 – PATIENT INFORMATION (if not the Participant)

Name

Date of Birth

Phone number

Email Address

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child

PART 3 – APPEAL INFORMATION

Claim Number, if applicable

Date of Service, if applicable

Are you being billed by the provider? ☐ Yes ☐ No (If yes, please attach a copy of the bill.)

Please explain the reason for the appeal (attach additional pages if needed):

Attach any information you feel will aid the Trustees in deciding on your appeal.

PART 4 - SIGNATURE

X _____
Appellant's Signature

Date

Print Name

REVISED AUGUST 2023