ARBENEFITS Appeal Request Form

Only ARBenefits members may file an appeal to the Employee Benefits Division (EBD).

*The following drug categories are **excluded** from coverage. EBD will **NOT** review any appeal for excluded categories. This serves as notice of denial and response in said cases. There will be no further correspondence.*

- *Weight-Loss*
- *Over-the-Counter (OTC)*
- *Gender Dysphoria*
- *Anti-Wrinkle Agents*
- *Hair Growth Stimulants*
- *Infertility or Abortifacient*

Member Information

First Name	Last Name		
Member ID or Social Security Number	Daytime Phone Number	Date of Birth	
Street Address	City	State	Zip Code

Authorized Representative if not member

*If you are requesting an appeal on behalf of the member, an **Authorization to Release Form** must be completed and either be submitted with this form or on file with ARBenefits. ****Providers are not to submit appeals.*****

First Name	Last Name	Daytime Phone Number	
Street Address	City	State	Zip Code

Medication Information

Only fill out this section if you are making a pharmacy appeal.

Medication	Currently taking? ☐ Yes ☐ No	If yes, date started:	Quantity
Dosing Schedule	Strength of Medication	Diagnosis	

Appeals MUST Include:

- This completed form.
- Letter describing the reason for your appeal.
- Additional supporting documentation from your physician.

Keep copies of this form, your denial notice, and ALL documents and correspondence related to this claim.

Member Signature: _____ Date: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
ATTN: Appeals Department - PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-6516