

**REQUEST TO WITHDRAW APPEAL FORM**

<Member Name :> Member ID:

Case ID:

I HEREBY WITHDRAW MY APPEAL REQUEST FILED ON <Date> FOR <brief description of the appeal issue >.

MEMBER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[MEMBER’S Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

REPRESENTATIVE’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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REPRESENTATIVE’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE RETURN THIS FORM BY** **<date>.**

**PLEASE RETURN THIS FORM TO:**

Clover Health

Attention: Appeals and Disputes

<P.O. Box 471

Jersey City, NJ 07303>

*Clover Health is a Preferred Provider Organization (PPO) with a Medicare contract. Enrollment in Clover Health depends on Contract Renewal.*