Bennington College
Health and Psychological Services Appeal Form

If you currently have insurance, call your insurance carrier to ask about and confirm your coverage before completing this form. Phone numbers are typically located on the back of your insurance card. Check here if you have been in contact with carrier: □

Complete this form if you are requesting a payment plan or reduction of medical charges or insurance premiums. On the back explain why you are in need of reduction. Please be advised that submitting an appeal does not guarantee an adjustment to your medical charges or insurance cost and responsibility.

I. Student Information
5-Digit ID#____________________ Date: ___________________________
Name:_________________________________________ Phone: ________________________________

II. Appeal Information □ check if international student; home country: _________________________
Indicate the type of financial consideration you are in need of (mark all applicable):

☐ Consideration of current billing statement and past charges
  Adjustment to bill - requested reduction amount: $_______________________________

☐ Consideration for future care with Psych Services
  Adjustment to copay - what amount can you pay per session: $_____________________

☐ Consideration for future care with Medical Services
  Adjustment to copay - what amount can you pay per session: $_____________________

☐ Consideration for financial support of health insurance premium
  Adjustment to premium - what amount can you contribute: $_______________________

☐ Enrollment and payment plan for IFS Secure Plus Plan premium; administrative fee waived
  Payments must be paid in full via Populi before registration in April

☐ Other considerations ______________________________________________________

Current insurance carrier:_________________________________________ (☐ check if Medicaid
State insurance is based or issued:____________________________________ based policy)
Insurance Coverage is: □ In-Network or □ Out-of-Network at the Student Health Center
CoPay:__________________ Coverage notes: ______________________________________________
______________________________________________________________________________
______________________________________________________________________________
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for office use: EFC________________________ BMMS______________ Campus Hours Per Week______________
Term____________________ Populi_________________________ Student Status_____________________________
________________________________________________________________________________
________________________________________________________________________________
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III. Appeal Explanation

Please explain your situation and need for financial consideration. If there are any significant changes in your financial circumstances or special conditions which are not reflected in your financial aid history, please explain them here. Examples may include loss of income or resources due to death, divorce, unemployment, retirement, disability, layoff, change in child or spousal support; increased or excessive medical costs; need for medical privacy with parents; etc. Please refrain from explaining your specific medical care; this form is not confidential.

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Mail, fax, or email this completed form to the Business Office. The Business Office may contact you if further documentation or information is necessary before making a decision.

We are requesting a consideration of financial consideration and reduction. By signing below, I/we certify that the information above is true and correct to the best of my/our knowledge and belief.

______________________________________________________________________________________________________

Student Signature
Date

Parent Signature
Date

Parent Name: _____________________________________________ Custodial or Non-custodial

Parent Phone: ___________________________ Email: _________________________________