Bennington College
Health and Psychological Services Appeal Form

Before completing this form, call your insurance carrier to ask about and confirmed coverage. Appeal not reviewed until you confirm your coverage by calling your carrier. Phone numbers are located on the back of your ID card. Check here once you have been in contact with carrier: ☐

Complete this form if you are requesting a reduction of medical charges or insurance premiums. Explaining 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

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<th>ID#</th>
<th>Date</th>
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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):

☐ Review of current billing statement and past charges
☐ Consideration for future care with Psych Services
☐ Consideration for future care with Medical Services
☐ Consideration for financial support of health insurance premium
☐ Other considerations

Current insurance carrier: ____________________________ (☐ check if Medicaid
based policy)

Coverage notes: __________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What financial consideration are you requesting:

Adjustment to bill - requested reduction amount: $__________________ or
Adjustment to copay - what amount can you pay per session: $__________________ or
Adjustment to insurance premium - what amount can you contribute: $__________________ or
Reduced session fee - what amount per session do you feel you can afford: $__________________

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for office use:  FASFA _______ BMMS _______ Campus Hours Per Week _________
Populi _______ Term _______ Student Status _______
III. Appeal Explanation

Cause for review for medical charges or insurance premium 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, or a change in the number of family members in the household since you enrolled. Please provide a detailed statement below regarding the significant changes in your financial circumstances or describe any special conditions. Be very specific about the amount you are requesting. 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: _________________________________