Bennington College
Student Health Center Appeal Form

Before submitting an appeal, call your insurance carrier to ask about and confirm your coverage. Phone number is 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 based policy)

State insurance is based or issued:_____

Insurance Coverage is: ☐ In-Network or
☐ Out-of-Network at campus Health Center (NPI #1063851350)

CoPay:_____ Coverage notes: _____

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for office use: AGI/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 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, change in parent's child or spousal support; increased or excessive medical costs; need for medical privacy with parents; etc. Please refrain from explaining details of your specific medical situation; this form is not confidential.

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Mail, fax, or email this completed form to Teresa Sholes (contact details below). You may be contacted if further documentation or information is necessary before making a decision.

I am requesting financial consideration and reduction. By signing below, I certify that the information above is true and correct to the best of my knowledge and belief.

_____

Student Signature *Date*

Parent Name: _____ Custodial or Non-custodial

Parent Email: _____ _____