

# Clover Health

## Form for Requesting to Withdraw an Appeal

Member Full Name:		
Member ID#:	Birth Date (MM/DD/YYYY): ____/____/____	Phone Number: (____) ____ - ____

I HEREBY WITHDRAW MY APPEAL REQUEST FILED ON (date) \_\_\_\_/\_\_\_\_/\_\_\_\_ FOR  
(brief description of the appeal issue):

<b>Complete the following section ONLY if the person making this request is not the member:</b>
Representative Name:
Phone Number: (____) ____ - ____
<b>Signature:</b>
Member or Representative Signature:
Today's Date (MM/DD/YYYY): ____/____/____

Please Return Form to:  
Clover Health  
Attention: Appeals and Disputes  
P.O. Box 2091  
Jersey City, NJ 07303

Clover Health is a Preferred Provider Organization (PPO) plan and a Health Maintenance Organization (HMO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal. This information is not a complete description of benefits. Call 1-888-778-1478 (TTY 711) for more information.