HEALTH REPUBLIC INSURANCE OF NEW YORK
LIQUIDATION ADMINISTRATION

APPEAL BY MAIL FORM FOR HEALTH SERVICE PROVIDERS

Please submit this form with supporting papers, if any, within 60 days of the date of the Explanation of Benefits (EOB)/Allowance to:

Health Republic Insurance of New York
Case Administration c/o GCG
P.O. Box 10266
Dublin, OH 43017-5766

CLAIM(S)

Select One: I object to ☐ the entire EOB ☐ Specific claim(s)

Claim Number *	Date of Service (Number* DOS) *	Charged Amount *

HEALTH SERVICE PROVIDER

Voucher Number *	
Health Service Provider Name *	
Address *	
City, State and Zip *	
Contact Person *	
Email *	
Phone *	

*** - required fields**

REASON FOR APPEAL*

Date *	