

Clover

Request to Withdraw Appeal Form

I HEREBY WITHDRAW MY APPEAL REQUEST FILED ON (date) _____ FOR
(brief description of the appeal issue)

Member's Name: _____

Member's Signature: _____

Representative's Name: _____

Representative's Signature: _____

Date Signed: _____

Please Return Form by (date:) _____

Please Return Form to:

Clover Health
Attention: Appeals and Disputes
P.O. Box 471
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.