Hartford HealthCare Medical Group

APPEAL FORM FOR REACTIVATION TO HARTFORD HEALTHCARE MEDICAL GROUP

DATE:_____

PATIENT NAME_____

DATE OF DISCHARGE FROM PRACTICE_____

OFFICE_____

PHYSICIAN NAME_____

I wish to appeal the decision of being discharged from the Practice of Hartford HealthCare Medical Group for the following reasons:

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Please note: Hartford HealthCare Medical Group charges a $50 processing fee to cover the costs of all administrative and billing tasks associated with the discharge/reactivation process. Please make payment payable to Hartford HealthCare Medical Group. This payment must be accompanied with the reactivation request.

_____ _____

Signature Date

Please forward to: Business Office
Hartford HealthCare Medical Group
200 Retreat Avenue
Research Building, 8th Floor
Hartford, CT 06106