Billing / No Show Appeal

SHS
Student Health Services
UC SAN DIEGO

Name: _____

Student ID#: _____

Phone #: _____

Appointment Info-

Date: _____

Time: _____

Provider: _____

Reason for Appeal:

_____

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Office use only:

Date Appealed / Denied_____ Amt._____

Voided__ Chg. Reversed__ Ins. notified__ Initial_____

Comments_____