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):

Complete the following section ONLY if the person making this request is not the member:
Representative Name:
Phone Number: (_____) _____- _____

Signature:
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