



**APPEAL FORM FOR REACTIVATION TO
HARTFORD 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 Medical Group for the following reasons:

Please note: Hartford 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 Medical Group. This payment must be accompanied with the reactivation request.

Signature

Date

Please forward to: John Fundock, COO
Hartford Medical Group
200 Retreat Avenue
Hartford, CT 06106