Appeal Form

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

You may appeal to OEBB about dependent eligibility decisions, enrollment errors and omissions, or missed enrollment timelines. OEBB does not process insurance carrier appeals because OEBB honors the confidentiality of personal health information that is protected by HIPAA law. If you disagree with a processed claim, denied procedure, or reimbursement decision, you must appeal directly to the insurance carrier. Please consult the corresponding plan member handbook for more information about the appeals process for that insurance carrier.

Complete and submit this form with all supporting documentation using one of the contact methods below. The appeal process will begin on the date this form is received by OEBB.

Member information

Last name | First name | Middle

Member ID, E number or Social Security number | Gender ☐ M ☐ F | Date of birth *(mm/dd/yyyy)*

Primary phone number | Work phone number | Cell phone number

May OEBB send text messages to this number? Standard text message and data rates apply. ☐ Yes ☐ No

Address ☐ Check if new address | Apartment or space#

City | State | ZIP | County

Work email | Personal email

What is this appeal for?

☐ Dependent Eligibility Verification
☐ Enrollment Error/Omission
☐ 12 Month Basic Services Waiting Period for Dental

Who is this appeal for?

☐ **Self**

☐ **Spouse** ☐ **Domestic partner** | Date of birth *(mm/dd/yyyy)* | Gender ☐ M ☐ F

Last name | First name | MI

Child of ☐ Self ☐ Spouse ☐ Domestic partner | Date of birth *(mm/dd/yyyy)* | Gender ☐ M ☐ F

Last name | First name | MI

Child of ☐ Self ☐ Spouse ☐ Domestic partner	Date of birth *(mm/dd/yyyy)*	Gender ☐ M ☐ F	
Last name	First name	MI	
Child of ☐ Self ☐ Spouse ☐ Domestic partner	Date of birth *(mm/dd/yyyy)*	Gender ☐ M ☐ F	
Last name	First name	MI	

Describe the problem

What change or action would you like to see take place? If applicable, please list the name of the plan(s) you would like to enroll in, change or cancel, as well as who is to be covered under each.

☐ Add enrollment ☐ Change enrollment ☐ Remove or cancel enrollment

Are you attaching or sending additional documents? ☐ Yes ☐ No

Please list additional documents:

Member signature and authorization

By signing below, I authorize OEBB to contact the carrier and/or employing entity to gather information to process this appeal.

Member signature

Date

Send completed form by

Mail
OEBB Appeals
500 Summer Street NE, E-88
Salem, OR 97301-1063

Email
benefit.appeals@state.or.us

Fax
503-378-5832