

PEBB Employee Request for Review/Notice of Appeal



Type or print clearly in dark ink. Example: **J O H N**
 Keep a copy of your completed form for your records.

If your situation is	and you	Follow these instructions and submission deadlines
<p>You are a current or former state agency or higher-education employee (or their dependent)</p>	<p>Disagree with a decision made by the employer and you are requesting the employer's review about premium surcharges or eligibility for or enrollment in:</p> <ul style="list-style-type: none"> • A premium payment plan • Medical coverage • Dental coverage • Life insurance • Accidental death and dismemberment (AD&D) insurance • Long-term disability (LTD) insurance • Medical Flexible Spending Arrangement (FSA) or Limited Purpose FSA • Dependent Care Assistance Program (DCAP) 	<p>Complete Sections 1 through 3 of this form and submit it to the employer's payroll or benefits office.</p> <p>Deadline: The employer must receive this form no later than 30 calendar days after the date on the denial notice regarding the decision you are appealing.</p>
	<p>Disagree with a review decision made by the employer, or further review is needed because the employer believes that there was an error but did not grant you the relief you requested, and you are now requesting the PEBB Appeals Unit review of the employer's decision</p>	<p>Complete Section 7, sign and date Section 9 of this form, and submit it to the PEBB Appeals Unit.</p> <p>Deadline: The PEBB Appeals Unit must receive this form no later than 30 calendar days after the employer's written review decision date in Section 4.</p>
	<p>Disagree with a decision from the PEBB Program about:</p> <ul style="list-style-type: none"> • Eligibility or enrollment in: <ul style="list-style-type: none"> ◦ A premium payment plan ◦ Medical FSA or Limited Purpose FSA ◦ DCAP ◦ Life insurance ◦ AD&D insurance ◦ LTD insurance • Eligibility to participate in SmartHealth or receive a wellness incentive • Eligibility and enrollment for a dependent, extended dependent, or dependent child with a disability • Premium surcharges • Premium payments 	<p>Do not use this form. Follow the appeal instructions on the decision letter you received from the PEBB Program.</p>

If your situation is	and you	Follow these instructions and submission deadlines
<p>You are a current or former employer group employee (or their dependent) of:</p> <ul style="list-style-type: none"> • A county • A municipality • A political subdivision of the state • A tribal government • An educational service district • The Washington Health Benefit Exchange • An employee organization representing state civil service employees 	<p>Disagree with a decision made by the employer about:</p> <ul style="list-style-type: none"> • Premium surcharges • Eligibility for or enrollment in: <ul style="list-style-type: none"> ◦ Medical coverage ◦ Dental coverage <p>Disagree with a decision made by the employer or the PEBB Program about:</p> <ul style="list-style-type: none"> • Eligibility or enrollment in: <ul style="list-style-type: none"> ◦ Life insurance ◦ AD&D insurance ◦ LTD insurance ◦ Eligibility and enrollment for a dependent, extended dependent, or dependent child with a disability • Eligibility to participate in SmartHealth or receive a wellness incentive 	<p>Do not use this form. Contact your employer for information on how to appeal the decision or action.</p> <p>Complete Sections 1 through 3 of this form, or submit a letter to the PEBB Appeals Unit as described in the denial letter from the PEBB Program. The PEBB Appeals Unit must receive this form no later than 30 calendar days after the date of the initial denial notice or decision you are appealing (see Section 7).</p>
<p>You are a current or former state agency or higher-education employee (or their dependent), or an employer group employee (or their dependent)</p>	<p>Are seeking review of a decision made by a PEBB medical or dental plan, insurance carrier, or contracted vendor about:</p> <ul style="list-style-type: none"> • A benefit or claim • Completion of SmartHealth requirements or request for a reasonable alternative to a SmartHealth requirement • Life insurance and AD&D insurance premium payments 	<p>Do not use this form. Contact the medical or dental plan, insurance carrier, or contracted vendor to request information on how to appeal the decision.</p>

Request for initial employer review

Employees, former employees, or dependents may appeal. Your appeal must comply with all applicable deadlines on pages 1 and 2.

1

Appellant information

To be completed by the person filing the request for review or appeal (the appellant).

Select one:

Employee or former employee

Dependent of employee or former employee

Applicant (not currently enrolled in PEBB benefits)

Employer name

Social Security number

Date of birth

Last name

First name

Middle initial

Street address

Address line 2

City

State

ZIP/Postal code

Mailing address (if different from above)

Address line 2

City

State

ZIP/Postal code

Phone number

Alternate phone number

Email address

Appellant's last name

First name

Middle initial

Other enrollee information — if appeal concerns people other than the appellant

Other enrollee 1

Last name

Middle initial

First name

Social Security Number

Other enrollee 2

Last name

Middle initial

First name

Social Security Number

2

Describe your request for review or appeal

Please be as detailed as possible. You may attach additional pages as needed. Describe the situation that led to your appeal and what you are asking for.

3

Appellant signature

Sign and date this section. Keep a copy of this form for your records. Submit the signed request to the employer for review, if applicable.

By submitting this form, I declare that the information I have provided is true, complete, and correct.

Appellant's signature

Date

Appellant's last name

First name

Middle initial

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Employer response to appellant's request for review

To be completed by the employer.

Instructions for employers: Complete Sections 4 through 6 (as applicable) to provide the requested review of your decision about the employee's or dependent's eligibility for benefits, enrollment, or a premium surcharge.

- Complete Section 4 and Section 6 after the appellant completes Sections 1 through 3; see WAC 182-16-2020 for guidance.
- **In addition, complete Section 5 if you agree that a wrong decision or action occurred.**
 - If correcting an enrollment error as described in WAC 182-08-187 and PEBB Program Administrative Policy 11-3, forward your recommendation for correction of the enrollment error by FUZE secure email to the PEBB Program (Outreach and Training Unit) for final determination. Send a secure online message from the FUZE webpage at hca.wa.gov/fuze-questions. You must set up a secure login for this feature.
 - For life, AD&D, or LTD insurance eligibility, enrollment, or premium issues, forward your recommendation to correct the decision or action caused by delay or error by FUZE secure email to the PEBB Program (Outreach and Training Unit) for final determination.
- Section 6 must be completed by a staff person who did not participate in the initial denial or decision-making process.
- After completing all required sections:
 - Return this form to the appellant within 30 calendar days of receipt.
 - Provide a copy to your agency administrator (or designee).

If the employer does not make a decision within 30 days, the appellant may contact the PEBB Appeals Unit.

Employer name

Agency/sub-agency code

Agency contact's last name

First name

Contact's phone number

Contact's email address

Date you received the appellant's request for review

Full name and job title of the person who made this initial denial or decision on the *Employee's request for review*
Last name

First name

Middle initial

Job title

List the PEBB Program rule(s) the denial or decision was based on, if known:

Appellant's last name

First name

Middle initial

Date of employer's review decision on Employee's request for review. The next level of appeal must be received by the PEBB Appeals Unit **no later than 30 days** after this date. If the PEBB Appeals Unit receives your appeal by the deadline, it will be considered timely.

Select one (employer must check only one box):

The employer stands by the denial. The appellant has the right to appeal this decision by completing Section 7. The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after the date of the employer's review decision noted above.

The employer believes that a wrong decision or action occurred and must complete Section 5.

Note: If the appeal relates to a decision made by the PEBB Program, the appellant is responsible for complying with the timelines described on the decision letter. (This form is not required if the PEBB Program has already sent a decision letter.)

5

Employer response (if applicable)

To be completed by the employer only when the employer agrees a wrong decision or action occurred.

Why do you believe a wrong decision or action occurred?

Agency delay

Agency error

Please explain the delay or error:

What do you recommend to correct the decision or action?

6

Employer signature

To be completed by a reviewer who did not participate in the initial denial or decision-making process under appeal, such as the employer's administrator or a designee. Complete this section after the employer completes Section 4 (and Section 5 if applicable).

Reviewer's last name

First name

Phone number

Reviewer's signature

Date

7

Employee notice of appeal to the PEBB Appeals Unit

To be completed by the appellant.

Instructions for appellant:

- Do not complete this section until you receive a completed copy of this form from the employer, unless you are directly appealing a decision made by the PEBB Program.
- If you wish to appeal the employer's decision, or you agree with the employer that a wrong decision or action occurred, complete this section, sign and date Section 9, and submit this form to the PEBB Appeals Unit as instructed below.
- You may attach a statement that identifies the specific portion of the decision you are appealing and explains why you agree or disagree with the employer's decision, and submit additional documentation for review.
- The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's review decision date in Section 4.

Response to the employer's reason for denial listed in Section 4, if applicable.

Additional information you want the PEBB Appeals Unit to consider that was not mentioned before.

Are you attaching additional documentation?

No.

Yes. I have attached additional documents, such as forms or correspondence between the employer or the PEBB Program and me. Please identify the document and the reason you are submitting it.

Appellant's last name

First name

Middle initial

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Representative information (if applicable)

If you have someone representing you, you must complete the *Authorization for Release of Information form* available on the HCA website at hca.wa.gov/health-care-services-supports under *Forms & publications*. Or, you may submit a power of attorney document. Please contact the PEBB Appeals Unit for more information at 1-800-351-6827.

Representative's last name

First name

Middle initial

Mailing address

Address line 2

City

State

ZIP/Postal code

Phone number

Alternate phone number

Email address

Relationship to appellant

Washington State Bar Association number (if applicable)

9

Appellant signature and electronic service option

Sign and date this section. Keep a copy of this form for your records.

Electronic service

By signing and providing my email address below, I agree to receive service of appeal documents and orders from the PEBB Appeals Unit by email. I understand that service is complete when the email is sent to the correct email address I have listed below, not when I view the email. I understand that the PEBB Appeals Unit will use a secure email platform to serve documents and orders on me at the email address below. (Please print clearly.)

Email address

This appeal form must be faxed or mailed to the PEBB Appeals Unit at the contact information listed below. By signing this form, I declare that the information I have provided is true, complete, and correct.

Appellant's signature

Date

How to submit this form

The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's review decision date in Section 4 to request a brief adjudicative proceeding.

Submit this form by mail or fax (choose one):

Mail:

Health Care Authority
Attn: PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504

Fax:

360-763-4709