Appeal Form

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 ◯ Other	Date of birth *(mm/dd/yyyy)*
Primary phone number	Work phone number	Cell phone number
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

Who is this appeal for? ☐ Self

◯ **Spouse** ◯ **Domestic partner**	Date of birth *(mm/dd/yyyy)*	Gender ◯ M ◯ F ◯ Other
Last name	First name	M.I.
Child of ◯ Self ◯ Spouse ◯ Domestic partner	Date of birth *(mm/dd/yyyy)*	Gender ◯ M ◯ F ◯ Other
Last name	First name	M.I.

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

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

Submit completed form by:

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

Email: benefit.appeals@odhsoha.oregon.gov

Fax: (503) 378-5832