



Appeal Form

You may appeal to OEGB about dependent eligibility decisions, enrollment errors and omissions, or missed enrollment timelines. OEGB does not process insurance carrier appeals because OEGB 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 OEGB.

Member information			
Last name	First name	Middle	
Member ID, E number or Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Date of birth (mm/dd/yyyy)	
Primary phone number	Work phone number	Cell phone number	
Address	<input type="checkbox"/> Check if new address	Apartment or space#	
City	State	ZIP	County
Work email	Personal email		

What is this appeal for?

<input type="checkbox"/> Dependent Eligibility Verification	<input type="checkbox"/> Enrollment Error/Omission
<input type="checkbox"/> 12 Month Basic Services Waiting Period for Dental	

Who is this appeal for? Self

<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Last name	First name	MI	
Child of <input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic partner	Date of birth (mm/dd/yyyy)
		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	
Last name	First name	MI	

Child of <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Date of birth (<i>mm/dd/yyyy</i>)	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Last name	First name	MI
Child of <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Date of birth (<i>mm/dd/yyyy</i>)	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
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 OEGB to contact the carrier and/or employing entity to gather information to process this appeal.

Member signature Date

Send completed form by

Mail	Email
OEGB Appeals	benefit.appeals@state.or.us
500 Summer Street NE, E-88	Fax
Salem, OR 97301-1063	503-378-5832