SEBB Continuation Coverage Notice of Appeal

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Clear form

- Type or print clearly in dark ink. Example: J O H N
- Keep a copy of your completed form for your records.
- The SEBB Appeals Unit must receive this form **no later than 60**[1] calendar days after the date of the denial notice or decision you are appealing.

If you are	And your appeal concerns	Follow these instructions
• An applicant for SEBB insurance coverage • A SEBB Continuation Coverage subscriber • A dependent of the above	A decision from the SEBB Program about: • Eligibility for benefits • Enrollment • Premium payments • Premium surcharges	Complete all sections of this form to request a brief adjudicative proceeding. Submit it to the SEBB Appeals Unit as instructed on page 4. The SEBB Appeals Unit must receive your appeal **no later than 60 calendar days** after the date of the initial denial notice or decision you are appealing.
Seeking a review of a decision by a SEBB health plan, insurance carrier, or benefit administrator	• The administration of the health plan or benefit • A benefit or claim	Do not use this form. Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.

1 Appellant information

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

- ☐ Applicant (not currently enrolled in SEBB Continuation Coverage)
- ☐ SEBB Continuation Coverage subscriber (including terminations)
- ☐ Dependent of a SEBB Continuation Coverage subscriber

Social Security number

Last name

First name | Middle initial | Suffix

Home phone number | Alternate phone number

Email Address

[1] If your initial appeal is confirmed as received by HCA by your appeal deadline, it will be considered timely. All future appeal-related deadlines must be received by the SEBB Appeals Unit within the relevant timeframes to be considered timely.

Appellant's last name | First name | Middle initial

Residential address

Address line 2

City | State

ZIP/Postal Code | County

Country

Mailing address (if different from above)

Mailing address line 2

City | State

ZIP/Postal Code | County

Country

Other enrollee information (if appeal concerns individuals other than the appellant)

Enrollee 1

Last name

First name | Middle initial | Suffix

Social Security number

– –

Enrollee 2

Last name

First name | Middle initial | Suffix

Social Security number

– –

Appellant's last name	First name	Middle initial

2 Describe your request for appeal

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

Are you attaching additional documentation? Please identify the document and the reason you are submitting it.

- ☐ No
- ☐ Yes. I have attached additional documents, such as forms or correspondence between my employer or the SEBB Program and me.

3 Representative information

If you have someone representing you, you must complete HCA's *Authorization for Release of Information* form. Please contact the SEBB Appeals Unit for additional information at 1-800-351-6827.

Last name

First name

Middle initial

Relationship to appellant

Washington State Bar Association number (If applicable)

Mailing address

Mailing address line 2

City

State

ZIP/Postal Code

Phone number

Appellant's last name	First name	Middle initial

4 Appellant signature

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

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

Signature

Date (mm/dd/yy)

How to submit this form

The SEBB Appeals Unit must receive this form **no later than 60 calendar days** after the date of the denial notice or decision you are appealing to request a brief adjudicative proceeding. Submit this completed form by mail or fax (choose one):

Mail
Health Care Authority
Attn: SEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Fax
360-763-4709