Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Retiree/PEBB Continuation Coverage Notice of Appeal

- Type or print clearly in dark ink.
- Keep a copy of your completed form for your records.
- The PEBB Appeals Unit must receive this form **no later than 60 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 PEBB insurance coverage • A retiree • A survivor of a deceased employee or retiree as described in Washington Administrative Code (WAC) 182-12-265 or 182-12-180 • A survivor of emergency service personnel killed in the line of duty as described in WAC 182-12-250 • A PEBB Continuation Coverage subscriber • The dependent of one of the above	A decision from the PEBB Program about: • Eligibility for benefits • Enrollment • Premium payments • Premium surcharges • Eligibility to participate in SmartHealth or receive a wellness incentive	Complete all sections of this form and submit it to the PEBB Appeals Unit as instructed on the next page.
Seeking a review of a decision by a **PEBB health plan, insurance carrier, or benefit administrator.**	• The administration of the health plan or benefit. • A benefit or claim. • Completion of SmartHealth requirements or a reasonable alternative request.	**Do not use this form.** Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.

Section 1: Appellant Information
To be completed by the person filing the request for review or appeal.

Select one:
- ☐ Retiree
- ☐ Applicant (not currently enrolled in PEBB coverage)
- ☐ Surviving dependent
- ☐ Dependent of a PEBB retiree or PEBB Continuation Coverage subscriber
- ☐ PEBB Continuation Coverage subscriber

Social Security number	Last name	First name	Middle initial	
Street address	Apt./Unit	City	State	ZIP Code
Mailing address (if different from above)	Apt./Unit	City	State	ZIP Code
Email address (if available)		Home phone ( )	Alternate phone ( )	

Other Enrollee Information *(if appeal concerns individuals other than the appellant)*

Social Security number	Last name	First name	Middle initial
Social Security number	Last name	First name	Middle initial

Appellant's last name	First name	Middle initial

Section 2: Describe Your Request for Appeal *Please be as detailed as possible. You may attach additional pages as needed.*
What was the date of the denial notice or decision?
What denial or decision do you want reviewed?
Why do you disagree with the denial or decision? Please give a detailed description of your situation and attach supporting documentation. Provide a statement identifying the specific portion of the denial or decision you are appealing, and clarify what you believe to be in error.
What would you like done about the denial or decision?
Are you attaching additional documentation? ☐ No. ☐ Yes. I have attached additional documents, such as forms or correspondence between the PEBB Program and me. **These documents show:**

Section 3: Representative Information *(if you have someone representing you)*				
Last name First name Middle initial	Phone number ( )		Email address	
Relationship to appellant	Washington State Bar Association number (if applicable)			
Mailing address Apt./Unit	City		State	ZIP Code

Section 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 ________________

How to submit this form:

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

Mail:
Health Care Authority
PEBB Appeals
PO Box 42699
Olympia, WA 98504-2699

Fax: 360-725-0771