PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Appeal Request Form

Complete the form using blue or black ink and attach a copy of your denial letter. Please print legibly and do not use a highlighter on this form or any attachments. This form will only be accepted if completed by the subscriber or an authorized representative. **A health care provider, employer or benefits administrator cannot serve as an authorized representative for an appeal to PEBA.** To designate an authorized representative, complete and attach an *Authorized Representative Form* (Form 7213).

Appeal information will be sent to your last address on file with PEBA.

Subscriber name: _____ **BIN or Social Security number:** _____

Patient name (if applicable): _____

Date of previous denial: _____ (*write N/A if not previously denied)*

Who denied your previous appeal?

- ❑ PEBA (eligibility and enrollment changes)
- ❑ BlueCross BlueShield of South Carolina (medical claims)
- ❑ Medi-Call (preauthorization of medical services)
- ❑ Companion Benefit Alternatives (behavioral health claims and preauthorization)
- ❑ Express Scripts (prescription claims and prior authorization)
- ❑ BlueCross BlueShield of South Carolina (dental claims)
- ❑ The Standard (long term disability benefits or incapacitated child certification)
- ❑ ASIFlex (MoneyPlus reimbursement or claim for MoneyPlus benefits)
- ❑ Other:_____ (*write N/A if not previously denied)*

Describe what you are appealing and attach additional information if needed.

_____

_____

_____

Does this appeal relate to a pregnancy, newborn child or preauthorization of a life-saving service or medication?

- ❑ Yes
- ❑ No

Authorized signature: _____ **Date:** _____

Return this form to PEBA's Insurance Appeals Division via email or mail before the applicable deadline.

Email: IAD@peba.sc.gov

Mailing address: S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223