Request for Review

Person Making the Request: _____

Subscriber's Name: _____

Subscriber's BIN or SSN: _____

Group Number: _____

Mail Completed Form to:

PEBA Insurance Benefits
Attn: Subscriber Services
P.O. Box 11661
Columbia, SC 29211-1661

FAXES ARE ONLY ACCEPTED FOR MEDICAL EMERGENCIES. CALL OFFICE BEFORE FAXING.

Change Requested:

_____ **Requested Effective Date:** _____

If BA Error, explain in detail:

Change Reason: BA Clerical Error or Delay* ☐ Subscriber Request ☐
See attached letter of justification/ explanations

_____ _____ _____
Benefits Administrator's Signature BA Phone Number Date

Completed Notice of Election Form (NOE) attached ☐ *Supporting documents attached* ☐

***No retroactive approval will be made unless a clerical error occurred.** Clerical errors made on the records of the Plan Administrator, Third Party Claims Processor or Utilization Review Agency, and delays in making entries on such records, shall not invalidate coverage that otherwise would be validly in force or cause coverage to be in force or to continue in force which would otherwise be terminated. Upon discovery of any such error or delay, an equitable adjustment will be made not to exceed 12 months contribution by the employee. Terminations are processed no more than 31 days retroactively. Employers are responsible for any premium liability more than 31 days retroactive to the date of termination.

PEBA INSURANCE BENEFITS USE ONLY:

Approved ☐ Effective date: _____

Denied ☐ Reason for denial: _____

_____

_____ _____
Benefits Counselor's Signature **Date**

If this request is denied, the Benefits Administrator must notify the subscriber by copy of this form of his right to ask for a review by writing to PEBA Insurance Benefits within 90 days of notice of this decision.

Revised 3/2013