Appeal request form

If you disagree with a decision regarding your health flexible spending account (health FSA), health reimbursement arrangement (HRA) account, dependent care assistance program (DCAP) or transportation benefit, you have the right to file a formal appeal.

Steps to appeal

- Your appeal must be submitted in writing and mailed, emailed or faxed to:

  BenefitHelp Solutions Fax: 503-765-3442
  Attn: BHS Appeals BHSappeals@benefithelpsolutions.com
  PO Box 67230
  Portland, OR 97268

- Your appeal must be received within 180-days of the date you received notification of the adverse decision to your account.
- Please include an explanation of why you disagree with the decision you are appealing. BHS is required to administer your plan as described in the Summary Plan Documents (SPD) provided by your employer and all Internal Revenue Service (IRS) regulations governing pretax benefit programs. Your chances of a successful appeal are greater if you familiarize yourself with your SPD and the IRS regulations and use them as the basis for your appeal.
- You may request copies of all documents and information related to your benefits at no cost to you.

Appeal review process

- Your appeal will be reviewed by a person who was not involved with the initial determination and who is not a subordinate of any person who was involved.
- The review will be a fresh look at your appeal without deference to the initial determination and will take into account all information submitted with your appeal.
- You will be notified of the decision regarding your appeal in writing by BenefitHelp Solutions within 60 days of the receipt of your written appeal, barring any further complications outside of BenefitHelp Solutions' control.

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Appeal form

PLEASE PRINT CLEARLY

*** This information is mandatory.** Reimbursement of your appeal may be delayed if fields with an asterisk are not filled out.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth	* SSN or BHS Identification number
			____/____/____	

* Mailing address	* City	* State	* ZIP

* Email address	* Contact phone number	☐ New address

* Employer

Section 2 Appeal information

* Adverse determination	* Determination date (MM/DD/YY)
	____/____/____

* Reason for appeal (continue on additional page if necessary)

* Other information relevant to your case (continue on additional page if necessary)

Section 3 Authorization

* Employee signature	* Signature date
X	

If filed by individual other than the participant: ☐ Spouse ☐ Child ☐ Other: _____

Ready to submit? Mail, fax, email or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268

Fax: 888-249-5058 **Email:** BHSappeals@benefithelpsolutions.com

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Section 4 Appeal information

* Additional information