

Appeal request

If you disagree with a decision regarding your continuation coverage, 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
Attn: BHS Appeals
PO Box 67230
Portland, OR 97268
Fax: 503-765-3442
BHSappeals@benefithelpsolutions.com
- 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 state and federal guidance regarding your coverage. Your chances of a successful appeal are greater if you familiarize yourself with your SPD and the applicable guidance 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.
- 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.

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN		
* Mailing address		* City	* State	* ZIP	
* Contact number	* Email address			<input type="checkbox"/> New address	
* Employer					

Section 2 Appeal information

* Adverse determination	* Determination date
* 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 X	* Signature date
If filed by individual other than the participant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	

Ready to submit? Mail or email to BenefitHelp Solutions Appeals.

Mail: BenefitHelp Solutions, Attn: BHS Appeals PO Box 67230, Portland, OR 97268

Email: BHSappeals@benefithelpsolutions.com

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

Section 4 Additional information

* Additional information