Claim Appeal Form

46632792 (12/18)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Enrollment may be delayed if fields with an asterisk are not filled out.

This form is used if you disagree, in whole or in part, with our decision regarding your claim for benefits, and/or you are enrolled in a plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), and are appealing our decision. You must file your request for review within 180 days of the date you receive your denial letter. Failure to file a timely appeal will bar you from any further review of this benefit denial under these procedures or in a court of law.

Upon request and free of charge, you will be provided (1) reasonable access to and copies of all documents, records and other information relevant to your claim; and (2) a copy of any specific rule, guideline or protocol relied upon in making the initial adverse benefit determination.

Once you submit this form to appeal our decision, you will receive a full and fair review of this adverse benefit determination and the review will be conducted by someone who was not involved in the initial claim denial and who is not a subordinate of anyone who decided the initial claim denial. You will be notified of the decision on your request for review within a reasonable period of time but not later than 60 days after the date your appeal is received. If you do not agree with the final determination on review and your claim relates to a plan subject to ERISA, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must exhaust the plan's review procedures before filing suit. In addition, any such action must be brought within the deadline described in your summary plan description. If your claims relates to a plan that is not subject to ERISA, you may have the right to appeal this decision. Review your benefit summary for a description of any appeal rights and procedures.

Please complete and submit this form along with supporting documentation for the claim in which you are filing an appeal.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* Social Security number
* Mailing address		* City	* State	* ZIP
* Physical address		* City	* State	* ZIP
* Email address			* Contact phone number	
* Employer				

Section 2 Claim information

Please provide the claim number and the reason for your appeal. Your reason for appeal should include what the claim was for and which IRS regulation you believe indicates that the claim should have been approved.

* Claim number
* Reason for appeal

Section 3 Participant certification

To the best of my knowledge, the information I am providing on and with this form is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that BenefitHelp Solutions, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN), and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify BenefitHelp Solutions. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

* Participant Signature	* Date

Return the completed form to BenefitHelp Solutions

Mail: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108 **Fax:** 855-778-9837

Questions? Contact BenefitHelp Solutions at 855-378-0197, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.