



Appeal Form

OEBB Use Only

Approved by _____

Date Approved _____

Effective Date _____

You may appeal to OEBB about dependent eligibility decisions, enrollment errors and omissions, Healthy Futures, or missed enrollment timelines. OEBB does not process insurance carrier appeals because OEBB honors the confidentiality of personal health information that is protected by HIPAA law. If you disagree with a processed claim, denied procedure, or reimbursement decision, you must appeal directly to the insurance carrier. Please consult the corresponding plan member handbook for more information about the appeals process for that insurance carrier.

Complete and submit this form with all supporting documentation using one of the contact methods below. The appeal process will begin on the date this form is received by OEBB.

1. Member Information

Last Name		First Name		MI
Member ID, Social Security Number, or E Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm/dd/yyyy)
Home Phone	Work Phone		Personal Email	
<input type="checkbox"/> Check if new address	Work Email			
Address			Apt or Space #	
City	State	Zip	County	

2. What is this appeal for?

- Dependent Eligibility Verification Enrollment Error/Omission
- 12 Month Basic Services Waiting Period for Dental and/or Vision

3. Who is this appeal for? Self

<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		Date of Birth (mm/dd/yyyy):	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Last Name		First Name	
MI			
Child of <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		Date of Birth (mm/dd/yyyy):	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Last Name		First Name	
MI			
Child of <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		Date of Birth (mm/dd/yyyy):	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Last Name		First Name	
MI			
Child of <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		Date of Birth (mm/dd/yyyy):	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Last Name		First Name	
MI			

500 Summer Street NE, E-88
Salem, OR 97301-1063



4. Describe the Problem

5. What change or action do you want to happen?

Add Enrollment Change Enrollment Remove or Cancel Enrollment
 Other:

6. Are you attaching or sending additional documents? Yes No

Please list additional documents:

7. Member Signature and Authorization

By signing below, I authorize OEBB to contact the carrier and/or employing entity to gather information to process this appeal.

_____ Member Signature

_____ Date

Send completed form by

Mail:
OEBB Appeals
500 Summer Street NE, E-88
Salem, OR 97301-1063

Email:
oebb.appeals@oregon.gov

Fax:
503-378-5832