Instructions for submitting a Claim Appeal Request

For Level 2 Internal Claim Appeals Only *

NOTE: This form should be used if you disagree with the outcome of your Level 1 appeal filed with PEBP's claims administrator or pharmacy benefits manager. For more information about the Internal Claim Appeal process, please refer to PEBP's Master Plan Document or contact PEBP at 800-326-5496 or 775-684-7000.

If, after a Level 1 appeal is completed, you are still dissatisfied with the denial of your claim, rescission of coverage, or amount paid on your claim you may submit your written request to the Executive Officer of PEBP or his designee (see the Plan Administrator's section of the Participant Contact Guide in this document for the address) within 35 days after you receive the decision on the Level 1 appeal, together with any additional information you have in support of your request. Your Level 2 appeal must include a copy of:

- ☐ The Level 1 review request;
- ☐ A copy of the decision made on review; and
- ☐ Any other documentation provided to the claims administrator by the participant.

The Executive Officer or his designee will use all resources available, including but not limited to, members of the staff of the Board, third party administrator, pharmacy benefit manager, Internet, and the PEBP Master Plan Document to determine if the claim was adjudicated correctly.

A decision on a Level 2 appeal will be given to you in writing within 30 days after the Level 2 appeal request is received by the Executive Officer or his designee, and will explain the reasons for the decision. If the appeal review results in a denial of benefits in whole or in part, it will explain the reasons for the decision, with reference to the applicable provisions of the plan upon which the denial is based. Submit your level 2 appeal to:

Executive Officer
Public Employees' Benefits Program
901 S. Stewart St., Ste. 1001
Carson City NV 89701

*Instructions for filing an External Review or Expedited Review is provided in PEBP's Master Plan Document. A separate form is required and is posted on the PEBP website under "Forms".

PEBP Claim Appeal Request Form

For Level 2 Internal Claim Appeals Only

Primary insured's name: _____

1. Patient's name if different:_____
2. Primary insured's PEBP ID # (located on your PEBP ID card):_____
3. Primary insured's contact telephone #: _____
4. Date appeal submitted to PEBP:_____
5. Description of the medical, dental or vision services denied:

   _____
   _____
   _____
   _____
   _____
   _____
6. Date(s) the medical, dental or vision services were provided:

   _____
   _____
7. Additional information PEBP should consider: (use a separate piece of paper if needed and attached it to this form).

   _____
   _____
   _____
   _____
   _____
   _____
   _____

I have attached the following information:

- ☐ Copy of my Level 1 review request submitted to PEBP's claims administrator;
- ☐ A copy of the decision made by PEBP's claims administrator, on review; and
- ☐ Copies of other pertinent information (attached to this form).

Signature of primary insured: _____