



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 775-684-7000 or 800-326-5496.

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 PEBP 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 claim's administrator by the participant.

The Executive Officer or his designee will use all resources available, including but not limited to, third party administrator, utilization management, pharmacy benefit manager, Internet, Nevada Revised Statute (NRS), Nevada Administrative Code (NAC) 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:

Public Employees' Benefits Program
Attn: Quality Control and Appeals Department
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".



Public Employees' Benefits Program (PEBP)

Level 2 Internal Claim Appeal Request Form

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

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

8. 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: _____