



Appeal Request Form

Type your information on the form, or use blue or black ink, and attach a copy of your denial letter. Print legibly and do not use a highlighter on this form or any attachments. This form will be accepted only if completed by the covered person at issue or their legal representative. **A provider, medical device or pharmaceutical manufacturer, employer, or agent of any of the foregoing cannot serve as a legal representative to appeal on the covered person's behalf.** To allow PEBA to communicate your personal health and insurance information to another party during the appeal process, complete and attach an [Authorized Representative Form](#) (Form 7213).

Appeal information will be sent to your last email and/or mailing address on file with PEBA.

Subscriber name: _____ **BIN or Social Security number:** _____

Patient name (if applicable): _____

Date of previous denial: _____ *(write N/A if not previously denied)*

Who denied your previous appeal?

- PEBA (eligibility and enrollment changes)
- BlueCross BlueShield of South Carolina (medical claims)
- Medi-Call (preauthorization of medical services)
- Companion Benefit Alternatives (behavioral health claims and prior authorization)
- Caremark (prescription claims and prior authorization)
- BlueCross BlueShield of South Carolina (dental claims)
- The Standard (long term disability benefits or incapacitated child certification)
- ASIFlex (MoneyPlus reimbursement or claim for MoneyPlus benefits)
- Other: _____ *(write N/A if not previously denied)*

Describe what you are appealing and attach additional information if needed.

Does this appeal relate to a pregnancy, newborn child or prior authorization of a life-saving service or medication?

- Yes No

Authorized signature: _____ **Date:** _____

Return this form to PEBA's Insurance Appeals Division via email or mail before the applicable deadline.

Email: IAD@peba.sc.gov

Mailing address: S.C. PEBA

Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223