Appeal Request Form

Employee name:	Employee Number:
Date:	Phone Number:

Explain the reason for your appeal. Please provide as much detail as possible, andinclude the reason you feel an error was made. See below for suggested information to Include in your appeal.

Please include the following information in your statement:
When was your benefits effective date?
Did you experience difficulty with enrollment?
What coverage do you currently have? Who do you cover?
Did you complete the PHA and Spouse Questionnaire?
Did you contact anyone for help?
Please include any communication with HR concerning your eligibility

Questions? Please contact HR direct connect at 828-213-5600 or submit a service ticket as described in this Mission and Me article https://missionandme.mission-health.org/scope/2021/08/10/changes-coming-to-hr-direct-connect-mailbox/