

MoneyPlus Appeal Form



If you disagree with a denied claim or adverse decision regarding your benefit, you may file a formal appeal. Your appeal **must be submitted in writing to ASIFlex using this form**. Your completed appeal form must be received within 31 days of the denial. Keep in mind that ASIFlex and your employer are required to administer the spending account plan as described in the Plan Document and in compliance with Internal Revenue Service (IRS) regulations. Your appeal will be reviewed and considered based on the information you submit. You will be notified of the decision regarding your appeal within approximately five business days of the receipt of your completed appeal form. You can view the plan document at www.peba.sc.gov/moneyplus.html. For information regarding ASI's HIPAA Privacy Policy, go to www.asiflex.com/SCmoneyplus.

Name															
SSN or ID Number	er														
Email address															
Street address															
City, State, Zip															
Employer name		S.C. I	PEBA – I	Money	/Plus										
					Idontifu		linforn			.I					
					identify	the clai	ım you	wish to	appea	31.					
Description of cla	aim														
Date of service															
Dollar amount															
Reason for appeal Describe the reason you disagree with the original claim decision. You must also submit a copy of the plan document provision or IRS regulation that supports your appeal. If you need additional space, you may add a blank page to submit with this form.															
	that supp	ports you	и аррсан	ii you iic	ca aaa	icionai 3	pace, y	ou ma	y dad d	biarik	puge	to subilitie	 113 101		
By signing this form, I certify that I have reviewed the plan document provisions. I understand that the plan is governed by IRS regulations. I understand that exceptions cannot be made to the plan document provisions or IRS regulations.															
Signature											С	Date			