



Appeals Process Quick Reference Guide

You have the right to appeal any FSAFEDS denial that involves your Health Care FSA, Limited Expense Health Care FSA, or Dependent Care FSA. Common reasons for appealing a claim include:

- A claim or request for reimbursement was not paid in full.
- A product or service that you believe is an eligible expense was denied.
- A request to change an election due to a [qualifying life event](#) was not approved.

Step 1: Informal Appeal

If you disagree with our decision or need additional information about your claim denial, please contact an FSAFEDS Benefits Counselor within 30 calendar days from the date of the decision to request a more detailed explanation. You may contact an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS (372-3337), TTY: 866-353-8058, Monday through Friday from 9 a.m. until 9 p.m., Eastern Time.

Step 2: First-Level Written Appeal

If you are not satisfied with the outcome of the informal appeal, you may request a formal appeal by following these steps:

- Submit your appeal request **in writing** to FSAFEDS for reconsideration. You must send FSAFEDS your written request within 60 calendar days of the initial decision. Be sure to sign your submission in order for it to be considered.
- Please include the following along with your written appeal request:
 - An explanation why you disagree with the denial. Please base your appeal on specific provisions outlined in the FSAFEDS Frequently Asked Questions (FAQs), IRS regulations that govern all pre-tax benefit programs, or other details at www.FSAFEDS.gov.
 - Copies of documents that support your claim, such as a physician's [letter of medical necessity](#), Explanation of Benefit (EOB) from your FEHB or other insurance plan, and/or detailed bills from your provider. If you choose, you may also submit information such as operative reports, medical records, or other medical details that support your claim.
- Fax or mail your appeal request and any necessary documentation to:
 - **Toll-free Fax:** 866-852-2599
 - **Mail:** FSAFEDS Program – Appeals, P.O. Box 14800, Lexington, KY 40512-4800

FSAFEDS has 30 calendar days from the date we receive your request to do one of the following:

1. Approve your appeal and process your claim.
2. Provide written communication that we have upheld the denial.

We will send you a notification of the outcome of your appeal. You will receive an email if you have an email address noted in your online account; if not, you will receive a letter in the mail.

Step 3: Second-Level Written Appeal

If you do not agree with our decision to uphold the denial, you have an additional 30 calendar days from the date of the denial to file another appeal for reconsideration. Please submit the appeal for reconsideration in writing and sign it prior to sending it to FSAFEDS. Upon receipt of the second appeal, the FSAFEDS Appeals Committee will meet to review and ensure that your appeal has been handled properly. This procedure includes a claims processing review and consideration of any new documentation that you may submit. We will make a decision on your second-level appeal within 30 calendar days from the date we receive your request.

If the FSAFEDS Appeals Committee reverses the denial, we will pay your claim.

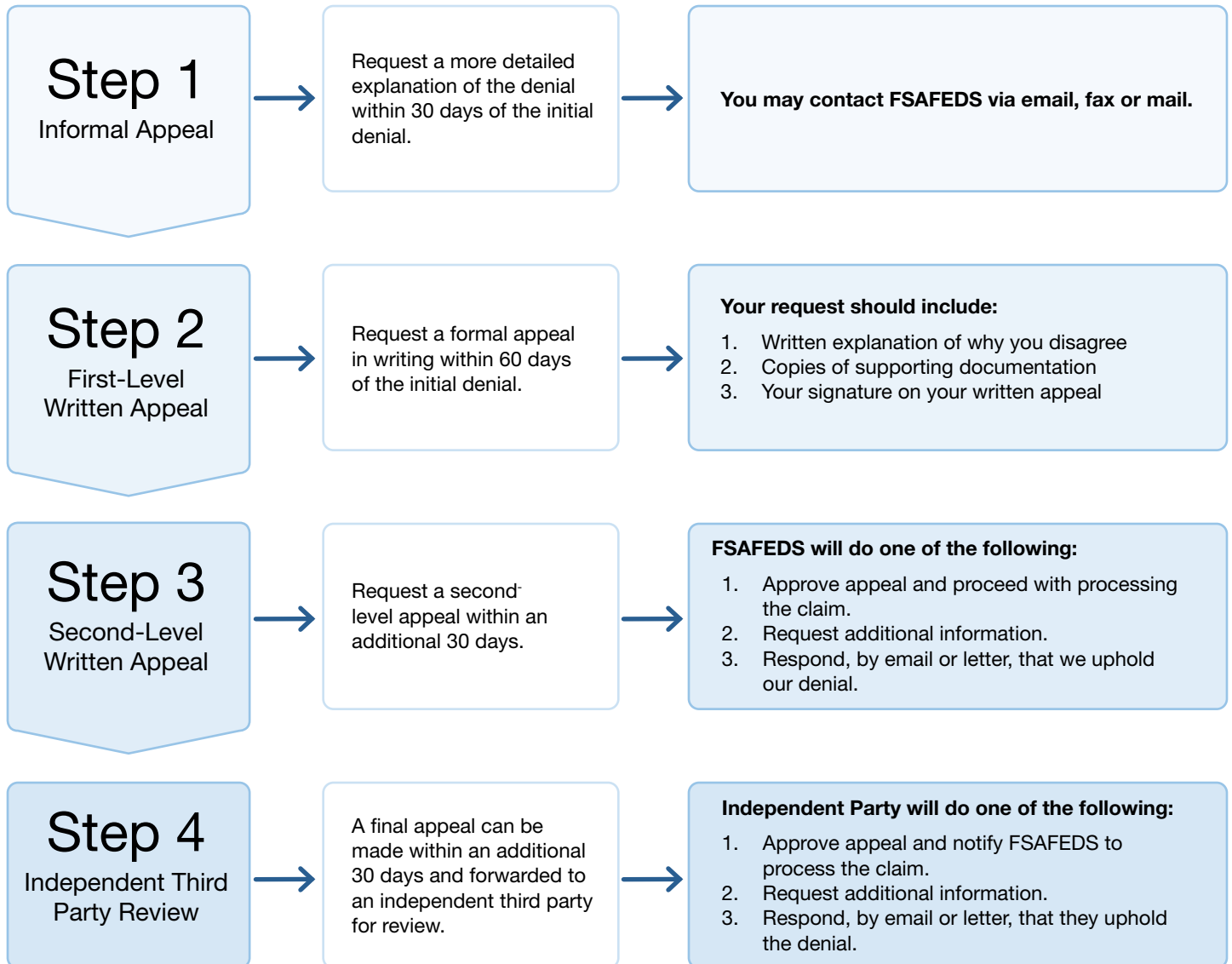
If the FSAFEDS Appeals Committee upholds the original denial, we will send you an email telling you why your claim does not meet IRS or Plan guidelines for reimbursement. The email will also let you know that you have the right to file a final appeal with FSAFEDS within 30 calendar days from the date of the denial, and it will be forwarded to an Independent Third Party for review. If we do not have your email address on file, we will send you a letter to the mailing address we have listed in your online account.

Step 4: Final Appeal for Independent Third Party Review

If you do not agree with our decision to uphold the denial of your second-level appeal, you will have an additional 30 calendar days from the date of the denial to file another appeal for reconsideration. Please submit the appeal for reconsideration in writing and sign it prior to sending it to FSAFEDS.

An independent third party reviews all documentation submitted for final appeal. The arbitrator has 30 calendar days from the date your final appeal request is received to review your appeal and respond to you by email. If we do not have your email address on file, a letter will be sent to the mailing address listed in your online account. The final decision is binding and cannot be appealed further by you, or OPM, or HealthEquity.

FSAFEDS Appeals Process





Information

For your reference, copies of documents and information related to the denied claim are available online by accessing the denied claim from your participant portal (log in at www.FSAFEDS.gov).
For more information on the appeals process you may visit our File an Appeal page <https://www.FSAFEDS.gov/file/appeal>.

Instructions

1. Complete the Appeal Form
2. Attach any documents, records, or other information that relates to the appeal.
3. Mail (recommended) or fax the completed appeal form and any additional information to:
Mail: FSAFEDS Program - Appeals
P.O. Box 14800
Lexington, KY 40512-4800
Toll-free Fax: 866-852-2599

Account holder information

Agency name	Last 4 of SSN <i>(Please do not include your full SSN)</i>		
Last name	First name	M.I.	
Street address	City	State	ZIP
Email address	Daytime phone ()		

Appeal information

Provider	Appeal submission date	Actual date(s) of service Start date: ___/___/___ End date: ___/___/___
Amount requested	Disputed amount	
Claim Form number	Type of account (Health Care FSA, Dependent Care FSA)	

Explanation of appeal

Use the space provided to explain your concern. Include names, dates when possible, any additional supporting documentation, and any other applicable information that clearly supports your appeal. (If more room is needed, please attach an additional page.) Attach any documentation necessary to support your claim. **Send only copies of receipts.** Keep original receipts for your records.

Account holder signature

Account holder signature	Date
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