

# CONSOLIDATED BILLING APPEAL FORM

<b>Home Department Number</b>	<b>Home Department Name</b>	<b>Date</b>
<b>Employee ID Number</b>	<b>Employee Name</b>	
<b>DPA/Fund</b>	<b>Coverage Period</b>	

Information needed to complete the box below can be found on the IINS (Insurance) Screen in OLPPS.

Plan	Description	Coverage	Dept. Contribution	Employee Cost	Coverage Period
Dental		<input type="checkbox"/> Single <input type="checkbox"/> 2Party <input type="checkbox"/> Family			
Medical		<input type="checkbox"/> Single <input type="checkbox"/> 2Party <input type="checkbox"/> Family			
Vision		<input type="checkbox"/> Single <input type="checkbox"/> 2Party <input type="checkbox"/> Family			
<b>GRAND TOTAL</b>					

<b>Explanation of Discrepancy</b>
-----------------------------------

- Employee on Leave Without Pay**  
*Contact the Payroll Office. Arrangements have not been made to end benefits for employee who has chosen not to be covered for insurance.*
  
- Employee has separated and coverage period has passed**  
*Separate the employee in OLPPS via the SEPR (Separation) Bundle.*

<b>Department Authorization</b>
<b>Print Name of Authorization Department Representative:</b> _____  <b>Signature:</b> _____ <b>Extension:</b> _____ <b>Date:</b> _____

<b>For Payroll Use Only</b>	
<b>Processed by</b> _____ <b>Date</b> _____	<input type="checkbox"/> <b>Approved</b> <input type="checkbox"/> <b>Denied</b>
<b>Reason for Denial</b>	

**Return completed form and a copy of the Consolidated Billing Memo to campus Esther Carmona - Payroll, Box 0812 within 30 days of date of memo.**