State Health Benefits Program
Agency Request for Assistance

Section 1: Complete information about the member.

EMPL ID: ______________________________ Participant's Name: __________________________

Member's Name: ______________________ Health Plan: ________________________________

Section 2: Agency information.

Agency/Payroll Group Number:_______/_______ Agency Name:_________________________________

Contact's Name:___________________________ Contact's Phone Number:

Contact's Fax Number:_______________________ Contact's E-mail Address:________________________

Section 3: Check the type of request and attach all supporting documents.

ADD NEWBORN

ACCESS TO COVERAGE

FSA Issue

Agency Error—System Date(s)

Plan Change (other than HIPAA event)

Void Event in Cardinal

No SSN - attach immigration paperwork

System Error Message (attach screenprint)

Eligibility Review- attach paperwork

Prescription Drug Denial

Ineligible Dependent

New Hire (Retro >30 Days)

OHB Payroll Approval (include details for request)

Claim Issue (identify type below)

Medical Behavioral Health Dental Prescription Drug Other

Vendor Complaint (identify which vendor)___________________________

Description of Issue/Complaint:

*Fax Form to OHB at **(804) 371-0231** or e-mail to **ohb@dhrm.virginia.gov**.*
Questions? Call 1-888-642-4414 or (804) 225-3642 in Richmond.