

Enterprise Holdings Benefit Issue Resolution Request Form

Mail or fax this completed form to:
Privacy Officer, Enterprise Holdings
 600 Corporate Park Drive, St. Louis, MO 63105
 Fax: 314-512-5824

You must complete and mail or fax this form directly to the Enterprise Holdings Privacy Officer. **Do not submit this form to your HR department.** The Privacy Officer will forward to the Corporate Employee Benefits department for resolution. Upon receipt, the Corporate Employee Benefits department will contact you by email to confirm receipt of form and will forward the resolution via email upon completion. If you prefer to receive correspondence from the Corporate Employee Benefits department by some method other than email, please indicate below:

I prefer to receive correspondence by: Email Phone Mail Fax

Employee name		Employee No.	Group/Region
Mailing address, city, state, zip		Alternate ID Number	
Email address	Daytime phone	Fax number	

Benefit Issue Overview This information is required before submitting to the Corporate Employee Benefits department. Incomplete forms will be returned.

Date benefit carrier contacted: _____ Name of benefit carrier representative contacted: _____
 Claim involves: (Check the appropriate box) Medical Dental Prescription Drug Vision HCSA EAP
 Date of service: _____ Claim number: _____ Claim amount: \$ _____
 Did the patient receive an Explanation of Benefits (EOB)? YES NO If yes, attach a copy.

Benefit Issue

Patient's name: _____
Explanation of issue (in detail): Please attach any document pertaining to this claim (e.g., Explanation Of Benefits, Claim Form, etc.) and include name of physician, dentist, psychiatrist, EAP counselor, etc. who provided the service(s). **Please write legibly.**

Employee Authorization

I authorize the Corporate Employee Benefits department to obtain, use and disclose any protected health information or other information which it determines in its judgment may be useful in attempting to resolve the claim, complaint, difficulty or problem identified above. This authorization will remain in effect until I revoke it or the problem identified above has been resolved to my satisfaction. I release and discharge Enterprise Holdings from any liability with respect to the use or disclosure of this information and acknowledge that my treatment, payment and enrollment in a health plan is not conditioned on execution of this authorization. I understand that information used or disclosed pursuant to this authorization may no longer be protected by federal or state law.

Employee signature: _____ Date submitted: _____

Corporate Employee Benefits Department Use

This section to be completed by Corporate Employee Benefits department.

Date form is received: _____ Corporate Employee Benefits Supervisor: _____

Date resolution is returned to employee: _____ Privacy Officer authorization: _____ (Signature) _____ (Date)

