OPERS

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377) www.opers.org

Disability Benefits Appeal Request Form

You have the right to file an appeal of the OPERS Board of Trustees' denial or termination of your disability benefit.

Instructions: Please choose 1, 2 or 3 below and complete the form accordingly.

1) File a request to appeal, seek an extension at a later date (if needed):
If you wish to file a request to appeal please complete Sections 1, 2 and 4 of this form. OPERS must receive this form within 30 days from the date of the letter notifying you of the Board's decision denying or terminating your disability benefits. You will have 45 days from the date OPERS receives this form to submit your completed Report of Physician form (DR-APS) and any additional objective medical evidence you deem necessary.

2) File a request to appeal and request an extension to submit your additional objective medical evidence:
If you wish to file a request to appeal and request an extension please complete all sections of this form and return it to OPERS within 30 days from the date of the letter notifying you of the Board's decision. You will have 90 days from the date OPERS receives this form to submit your completed Report of Physician form (DR-APS) and any additional objective medical evidence you deem necessary.

3) If you previously filed a request to appeal and now need to request an extension:
Please complete Sections 1, 3 and 4 and return this form to OPERS no later than 45 days from the date OPERS received your initial request to appeal. Submitting this request for an extension will allow you an additional 45 days to provide your completed Report of Physician form (DR-APS) and any additional objective medical evidence you deem necessary.

Important: Please note, Managed Medical Review Organization (MMro) may be contacting you regarding your appeal.

Section 1 - Member's Personal Information

Social Security Number

Gender Male Female

Date Of Birth Month Day Year

First Name MI Last Name Suffix

Street or Mailing Address Apt. Number

City State ZIP Code -

Home Phone Number Work Phone Number Cell Phone Number

Preferred Telephone Number for Contact: Home Work Cell

Preferred Time to Call: Morning Afternoon Evening

E-mail Address

Section 2 - Appeal Request

Important - Choosing to appeal this decision requires you to submit a Report of Physician form (DR-APS). You must submit the Report of Physician form (DR-APS) and any additional objective medical evidence to support your claim no later than 45 days from the date OPERS receives your initial Appeal Request form.

Please mark the following box if applicable:

☐ **Appeal Board's Decision - I am choosing to appeal the retirement board's decision to deny/terminate my disability benefit. I will forward my completed Report of Physician form and any additional objective medical evidence to support my claim.**

Section 3 - Appeal Extension Request

Important - This extension request must be received within 45 days from the date OPERS receives your initial Appeal Request form.

Please mark the following box if applicable:

☐ **Extension Request - I request an additional 45 days to submit my completed Report of Physician form and any additional objective medical evidence to support my claim.**

Section 4 - Member's Acknowledgment

HIPAA DISCLOSURE:
I authorize any licensed physician, medical provider, medical facility or provider of health care or similar entity to release any and all of the following information to OPERS or their third party administrators:

Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OPERS and their third party administrators.

I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying OPERS.

I understand that revoking this Authorization may impair necessary processing of my OPERS benefits.

I understand and acknowledge that my appeal request will not be reviewed and decided upon by the OPERS Board of Trustees until the expiration of the time frame allowed for me to submit my completed Report of Physician form and objective medical evidence supporting my claim.

Member Signature_____ Month ☐☐ Day ☐☐ Year ☐☐☐☐

Do not print or type name