

EXCEPTION FORM

FOR HEALTH BENEFITS REPRESENTATIVE USE ONLY

E-mail completed forms securely to hbr.inquiries@nctreasurer.com. If you do not have the ability to e-mail this form securely, please go to <http://nctreasurer.shp.leapfile.net/>. Follow the instructions here. **The following sections must be completed or the exception will not be processed:**

Agency/Organization Name

HBR Contact Name

HBR E-mail Address

Phone

Type of Request: Reinstatement

Retro Term

Retro Add

Change Term Date

Change Effective Date

Premium Credit

Other

How Was Error Made: Member

HBR

System/BF

Today's Date:

Effective Date of Requested Change:

SUBSCRIBER'S PERSONAL INFORMATION

Record name and mailing address	Telephone Number
	Employee SS# or SHP Member ID#

REASON FOR EXCEPTION *(Include reason for delayed notification):*

TO BE COMPLETED BY STATE HEALTH PLAN

Date Received:	Date of Decision	Approved	Denied
Reason if denied:			
SHP Rep. Name			

TO BE COMPLETED BY BCBSNC IF APPROVED

Date Received:

Date Completed:

BCBSNC Representative Name:

Phone Number: