

# 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  Tobacco Cessation  
 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: \_\_\_\_\_

***This section to be completed by Corporate Employee Benefits department.***

Date form received: \_\_\_\_\_ Benefits Supervisor: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)  
 Date form submitted to Benefits Manager: \_\_\_\_\_ Benefits Manager: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)  
 Date resolution returned to employee: \_\_\_\_\_ Privacy Officer: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

