



Exception Form

FOR HEALTH BENEFITS REPRESENTATIVE USE ONLY

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](#).

(E-mail completed forms **securely** to hbrinquiries@shpnc.org)

The following sections must be completed or the exception will not be processed.

BEACON AGENCY

BENEFIT FOCUS AGENCY

PAPER AGENCY

Agency Name _____

HBR Contact Name: _____

HBR E-mail Address: _____ Phone: _____

Type of Request: Reinstatement Retro Term Retro Add (attach change or enrollment form)
 Change Term Date Change Effective Date Other

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 #

ADDITIONAL SUBSCRIBER INFORMATION (IF APPLICABLE):

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 Representative Name: _____

TO BE COMPLETED BY BCBSNC IF APPROVED

Date Received: _____ Date Completed: _____

BCBSNC Representative Name: _____ Phone Number: _____