

## Agency Request For Assistance

### To be completed by Agency:

**Step 1: Complete information about yourself:**

Agency/Payroll Group Number:    /     
 Agency Name: \_\_\_\_\_  
 Agency Contact's Name: \_\_\_\_\_  
 Agency Contact's Phone Number: \_\_\_\_\_  
 Agency Contact's E-mail Address: \_\_\_\_\_  
 Agency Contact's Fax Number: \_\_\_\_\_

**Step 2: Complete information about the member:**

Member's BES ID:    --   --    
 Member's Name: \_\_\_\_\_  
 Description of Problem: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Step 3: Check the type of request, attach all supporting documents and fax to (804) 371-0231:**

<p><b>Employee Services Team</b></p> <p>___ Agency Error - Policy/Administrative                  ___ Agency Error - Retro &gt;59 days                  ___ Ineligible Dependent                  ___ No SSN                  ___ Other</p>	<p><b>Systems Team</b></p> <p>___ Agency Error - BES Date(s)                  ___ BES Error Message                  (attach BES screenprint)                  ___ Re-enter BES Suspense Record                  ___ Other</p>
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### To be Completed by Office of Health Benefits:

**Employee/Retiree Services Representative:** Name: \_\_\_\_\_

\_\_\_ Adult Disabled Child  
 \_\_\_ Agency Error - More than 59-days retro  
 \_\_\_ Agency Error - Policy/Administrative  
 \_\_\_ Appeal Approved  
 \_\_\_ Exclude Member  
 \_\_\_ Ineligible Dependent  
 \_\_\_ No SSN  
 \_\_\_ Policy Exception approved by: Name: \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

___ Denied, closed in CSTS, and sent to File	Date: _____
___ Approved, closed in CSTS, and sent to File	Date: _____
___ Approved, open in CSTS, and sent to Systems	Date: _____
	CSTS No: _____

**Systems Representative:** Name: \_\_\_\_\_

\_\_\_ Not Keyed and returned to Employee Services Date: \_\_\_\_\_  
 \_\_\_ Keyed and returned to Employee Services Date: \_\_\_\_\_