Sentara® Health Plans

PO Box 66189
Virginia Beach, VA 23466

Dear Member:

Thank you for your request for information regarding the Plan's Complaint process. Please refer to your member materials for a detailed description of the Plan's complaint and appeals process. Enclosed you will find the following information to help guide you should you choose to file a complaint:

- Complaint Form
- Designation Authorization Form (to appoint someone such as a physician or family member to act on your behalf in filing a complaint or appeal)
- Release of Information (this form is used so that the Plan can assist you in obtaining pertinent medical information from practitioners or providers in which healthcare services have been delivered)

For the Plan to address your concerns, your complaint must be submitted within 180 days from the date of your concern with care, service and/or policies and procedures of the Plan. Please send the completed Complaint Form and any additional information related to your concerns to:

Sentara Health Plans APPEALS DEPARTMENT
P.O. Box 66189
Virginia Beach, VA 23466
OR
Facsimile: 757-233-6354
Toll-free facsimile: 1-877-240-4214

You will be notified in writing within five (5) business days that your information was received, and the time required to research your concerns. Procedures for handling complaints and the associated time frames for resolving complaints will vary by the type of complaint received.

Your continued satisfaction with the Plan is our primary concern. If you have any questions regarding your complaint, please call the Appeals Department at 1-833-702-0037.

Sentara®
Health Plans

COMPLAINT FORM

Today's Date: _____

Member ID #_____ Member's Name: _____

Address:_____

Home#:_____ Work#:_____

Date(s) of Service: _____ Provider/Facility: _____

Please describe the circumstances regarding your complaint. Use additional paper if needed.

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_____ _____

Signature **Date**

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A member has the right to designate an authorized representative, such as a provider or family member, to act on his or her behalf in filing an appeal of an Adverse Benefit Determination. This authorization may be granted for a particular event or date of service after which time the authorization is revoked, or may be granted for any present or future claim for healthcare benefits. Explanation of Benefit statements will not be directed to an authorized representative, but will continue to be sent to the Member**.** To designate an authorized representative, please complete this form and return to Sentara Health Plans Appeals Department.

Sentara Health Plans Designation Authorization Form Appeals Department

Member Name: _____

Member ID#: _____ Date of Birth: _____

Health Plan: ☐ Sentara Health Plans (SHP) ☐ Sentara Health Insurance Company (SHIC)

I hereby designate: _____

Name Relationship

_____

Address

_____

City, State, Zip

to act on my behalf in pursuing a claim for benefits or an appeal of an adverse benefit determination.

☐ This consent is valid for ____ days (Consent is valid for 180 days unless noted otherwise).

☐ Consent is valid until revoked by me.

I, the undersigned, understand that I may revoke this consent at any time. Also, upon fulfillment of the above-stated purpose, I understand that my authorized representative or I may receive a copy of the release. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for a period of 180 days, unless otherwise noted above.

(State date, event, or condition of expiration)

Signed _____ Date _____

AUTHORIZATION TO RELEASE & OBTAIN PROTECTED HEALTH INFORMATION (PHI)

PLEASE PRINT *FIRST* *MIDDLE* *LAST*

Member's Name: _____

Month *Date* *Full 4-Digit Year*

Member ID # : _____ Date of Birth: _____

I authorize ☐ ***Sentara Health Plans*** *or* ☐ _____ to exchange information with:

Individual: _____

Agency: _____

Address: _____

_____

Phone Number: _____

☐ Family _____
Relationship

☐ Employer ☐ EAP

☐ Aftercare ☐ Physician

☐ Therapist ☐ Referral Source

☐ _____

For The Purpose of: ☐ *Diagnosis, Treatment & Discharge Planning, Continuity of Care* OR ☐ _____ (Be Specific)

This authorization covers the following Protected Health Information (PHI)

To Be RELEASED	To Be OBTAINED
Dates of Service _____ **to** _____ *(INSERT DATES OF SERVICE FOR INFORMATION TO BE RELEASED)*	**Dates of Service** _____ **to** _____ *(INSERT DATES OF SERVICE FOR INFORMATION TO BE RELEASED)*
☐ Claims Information	☐ List Information Being Requested:
☐ Clinical Notes	☐
☐ Demographics & Benefits	☐
☐ Other:	

NOTICE TO PARTY RECEIVING DRUG/ALCOHOL ABUSE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PROHIBITION ON REDISCLOSURE: The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse member. This information is confidential and protected by Federal Law. Any further redisclosure is strictly prohibited unless patient provides specific written consent for the subsequent disclosure of this information. This authorization is subject to patient revocation at any time except to the extent that action has already been taken.

If not previously revoked, this consent will expire (check one): ☐ 30 days ☐ Other: _____
(*Specify Date or Event*)

I voluntarily sign this authorization, and I understand that my healthcare will not be affected if I do not sign this form. I also understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by written notification. I understand that my revocation or modification of this authorization will not affect any actions taken by the entity in reliance on this authorization before it receives my request for revocation or modification. I must sign my written request and include it with my complaint or appeal documentation.

Patient / Representative Signature	**Patient / Representative PRINTED Name**	**Date (Month/Day/Year)**
IF NOT SIGNED BY PATIENT, AUTHORITY TO SIGN ON BEHALF OF PATIENT:		
Witness Signature	**Witness PRINTED Name**	**Date (Month/Day/Year)**

INCLUDE THIS COMPLETED FORM WITH YOUR COMPLAINT OR APPEAL DOCUMENTATION

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260