Sentara® Health Plans

PO Box 66189
Virginia Beach, VA 23466

Dear Member:

Thank you for your request for information regarding the Plan's Adverse Benefit Determination Appeals Process. Please refer to your member materials for a detailed description of the Plan's appeal procedures. Enclosed you will find the following information to help guide you should you choose to file an appeal.

- Appeal Request Form
- Designation Authorization Form (to designate someone such as a physician or family member to act on your behalf in filing an appeal)
- Authorization for Use or Disclosure of Medical Information (this is also called a Release of Information and is needed so the Plan can assist you in obtaining pertinent medical information from the practitioners or providers)

To initiate the appeal process, please submit your request in writing 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 or your authorized representatives have the right to submit written comments, documents records or any other information relevant to your case. If you have difficulty in obtaining this information, please contact the Appeals Department for assistance.

Relevant information includes:

- the Appeal Request Form describing the services or procedures requested and an explanation of why you feel the Plan's decision was incorrect
- office notes from physicians that you have seen regarding the services or procedures in question
- medical records from hospitals and other healthcare providers
- physician correspondence
- physical, occupational, or rehabilitative therapy notes
- copies of bills you have received
- any additional information you would like the Plan to consider in reviewing your appeal

Upon the Plan's receipt of your written request, you will have ten (10) days to submit any additional medical information. Any documentation received after the 10th day may not be considered in your appeal review.

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.

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APPEAL INSTRUCTIONS

Upon receipt of the Appeal Form and any additional information submitted, your request will be reviewed by a person or persons not involved in the initial denial. The appeal review will take into account all comments, documents, records, and other information submitted by you or on your behalf relating to the claim, without regard to whether such information was submitted or considered in the initial determination.

Once your initial written request is received by the Plan, you will have ten (10) days to submit any additional information. Any documentation received after the 10th day may not be considered in your appeal review. New information may be submitted:

By mail:	Sentara Health Plans Appeals Department PO Box 66189 Virginia Beach, VA 23466	In person:	Sentara Health Plans 1300 Sentara Park Virginia Beach, VA 23464
By fax:	757-233-6354 1-877-240-4214		

Your appeal will be reviewed and a decision made within 30 calendar days for pre-service claims and 60 days for post-service claims. For more details, please refer to the Appeals Procedure section of your member materials.

Expedited Appeals - You or your physician may request an expedited appeal where if the Plan were to use its normal appeal procedure for making a decision it would (1) seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (2) in the opinion of a physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the, claim. If you believe you need an expedited appeal, please contact the Appeals Department at 1-833-702-0037. If your request does not qualify as an expedited appeal, the standard appeal process will apply.

SOURCES FOR ADDITIONAL INFORMATION

If you are not satisfied with the Plan's adverse benefit determination on your appeal, you may have the right to bring a civil action under ERISA Section 502(a). The local U.S. Department of Labor, Pension and Welfare Benefits Administration can assist Members in finding out what other voluntary alternative dispute resolutions are available. They may be reached at 1-866-275-7922.

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APPEAL REQUEST FORM

Today's Date: _____

Member ID #_____ Group Number: _____ Plan Name: _____

Member's Name: _____

Please check: ☐ Pre-Service ☐ Post ☐ Expedited/Urgent

Subscriber's Name: _____

Address: _____

Home #: _____ Work #: _____

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

Please describe the circumstances regarding the member's request for an appeal of an adverse determination. 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**. Due to the privacy of Protected Health Information, this form must be completed and returned when the member is 14 years or older and another person (e.g. parent, guardian) is acting on their behalf.** 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