Sentara Health Plans

PO Box 66189
Virginia Beach, VA 23466

Dear Medicaid Member,

Thank you for your request for information regarding Sentara Health Plans' Adverse Benefit Determination Appeal 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 Instructions.
- 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).

An appeal is a review by the health plan of an adverse benefit determination. An appeal may be submitted within 60 calendar days of an adverse benefit determination. Your appeal may be filed verbally or in writing. A verbal appeal filed by the member does not require follow-up with a written appeal. Appeals that are filed verbally will be handled in the same manner as written appeals. You, your attorney, your authorized representative of your choosing, or your doctor have the right to appeal an adverse benefit determination. Your authorized representative must have your written consent to appeal on your behalf. 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.

Your continued satisfaction with the Plan is our primary concern. If you have any questions regarding your appeal, please contact the Appeals Department at 1-844-434-2916 (TTY: 711).

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# APPEAL INSTRUCTIONS

To initiate a verbal appeal request, please phone the number below. To file a written appeal, please send the completed Appeal Request Form and any additional information related to your appeal to:

Mail: Sentara Health Plans
Appeals Department
PO Box 62876
Virginia Beach, VA 23466
Fax: 1-866-472-3920
Phone: 1-844-434-2916

If you need assistance in filing an appeal, or assistance with completing the steps in the process of filing an appeal, you may contact us at the phone number listed above.

Relevant information for your appeal may include:

- 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 your provider that you have seen regarding the services or procedures in question.
- Medical Records from hospitals and other health care 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.

You or your requesting provider can ask that your appeal be reviewed under an expedited (fast) process if you believe your health condition requires it. The internal appeal request must list that an expedited appeal is being requested and filed through one of the methods listed above. Your requesting provider will need to explain how a delay will cause harm to your physical or behavioral health. If we have all of the information we need, an expedited appeal decision will be made within 72 hours of receiving your appeal request.

If your request for an expedited appeal is denied, we will tell you, and the appeal will be reviewed under the standard process.

If you need assistance in filing an appeal, or assistance with completing the steps in the process of filing an appeal, you may contact us at the phone number listed above.

***Continuation of Benefits***

You can request that the services scheduled to end, be reduced, or suspended continue during your appeal. Services may be continued if your appeal request meets one of these requirements:

(1) You ask for an appeal within ten (10) calendar days of being told that your request is denied, or your care is

changing; or,

(2) You ask for an appeal by the date the change in the service is scheduled to occur.

When filing your internal appeal, let us know if you would like your benefits continued by stating you are requesting continued coverage in your appeal request.

It is important to know that if your appeal results in a denial, you may have to pay for any of the continued benefits received while the appeal was being handled.

***Processing the Internal Appeal***

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have the appropriate clinical expertise in the treatment of your condition or disease.

Before and during the internal appeal, you or your authorized representative can see or request copies of your case file, including medical records, any other documents and records, or any laws or policies being used to make a decision on your case. This information is available at no cost to you. You may request this information by calling the phone number listed above.

You can also provide information that you want us to use to make the decision on your appeal. If you want to provide more information, this information must be received with the appeal request or submitted within 10 business days of filing the appeal. If you need more time to provide this information to help us decide your case, you may request this by calling or writing to us using the contact information listed above.

You have the right to be represented by an attorney or other individual in the internal appeal process.

***Internal Appeal Timeframes***

Standard Appeals – If we have all of the information we need, we will tell you our decision within 30 days from the date your appeal was received. We will send you our decision in writing.

Expedited Appeals – If we have all of the information we need, we will tell you our decision within 72 hours from the date/time your appeal was received. We will tell you our decision by telephone and also send our decision in writing.

If More Information is Needed – If we need more information, we will write you and tell you what is needed. For an expedited appeal, we will call you and also send a written notice. We will tell you why we need the additional information. The request for more information will add up to 14 more days to the standard and expedited timeframes. If you do not agree with our decision to take more time to review your appeal, you may file a grievance.

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***Internal Appeal Decision***

We will tell you, and your authorized representative, if one is chosen, in writing of our appeal decision. If the decision is not in your favor, we will also explain the reason for the decision, including the citations to policies, procedures or authority that was used to make this decision and the name, title and qualifications of the person who made the decision. Once the internal appeal with Sentara Health Plans is exhausted, you have the right to request an appeal with the Department of Medical Assistance Services (DMAS).

***Appeals Rights to DMAS***

After Sentara Health Plans has made a decision on the internal appeal you filed, you have a right to appeal to DMAS. This is known as the State Fair Hearing. The appeal to DMAS must be filed within 120 days after receiving our internal appeal decision or it can be filed at any time if there is a deemed exhaustion because you believe we have failed to follow the notice and timing requirements for our internal appeal process. For further information on the DMAS appeal process, you can visit: www.dmas.virginia.gov/appeals or call the DMAS Appeals Division at 804-371-8488.

***FAMIS Members Only – Optional External Medical Review***

After we issue our final internal appeal decision, FAMIS members have the option of requesting an external medical review from Acentra Health (formerly KEPRO). It is not required that you request an external medical review to file a State Fair Hearing appeal request with DMAS. Additionally, if you request an external medical review and would like a State Fair Hearing appeal, you **must** still file the State Fair Hearing appeal with DMAS within 120 days after receiving our internal appeal decision.

***Help from an Advocate***

Call the free Legal Aid Helpline at 1-866-534-5243 or visit valegalaid.org to learn more about getting free legal advice or to ask for someone to possibly represent you in your appeal case.

***Help from an Advocate for LTSS Members***

If you would like to speak to an independent Advocate that can help you with questions, concerns or filing an internal appeal or request for a State Fair Hearing, please call 1-800-552-5019 or TTY toll-free 1-800-464-9950, Office of the State Long-Term Care Ombudsman, Department for Aging & Rehabilitative Services.

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# Appeal Request Form

| Name: (First Name, Middle Initial, Last Name): | | Date of Birth: |
|---|---|---|
| Street Address or PO Box, City, State, ZIP: | | |
| Member ID Number: | Main Phone Number: | Other Phone Number: |
| Doctor's Name: | | Doctor's Phone Number: |

I am appealing the action of Sentara Health Plans.

The date on the letter that I was told about Sentara Health Plans' decision is:

_____/_____/_____

The person who spoke or wrote to me telling me about the action that I am appealing is:

Name: _____ Title: _____

Sentara Health Plans has (check the space that best matches your appeal):

( ) Denied a service I asked for

( ) Stopped or ended a service I was getting

( ) Denied all or part of the cost for a service that Sentara Health Plans covers

( ) Other (please explain) _____

The service or drug you are appealing: _____

You are asking for an appeal because:

_____

_____

_____

**IMPORTANT:** Please send a copy of the notice or letter about the action you are appealing. If you are not the member, please be aware that Sentara Health Plans cannot move forward with this appeal until the member's written consent is received. Please send in supporting medical records, doctor's letters, or other information that explains why Sentara Health Plans should approve your appeal.

If you have a representative, list their information here (you do not need to have a representative):

Name: _____

Address: _____

Phone Number: _____

Signature of person making the appeal: _____ Date: _____

Signature of the Member: _____ 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 health care 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
PO Box 62876
Virginia Beach, VA 23466

## Designation Authorization Form
## Appeals Department

Member Name _____

Member ID# _____ Date of Birth _____

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.

_____ _____

Member Signature Date

Sentara Health Plans

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