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)
- Authorization to Release & Obtain Protected Health Information (PHI) (this 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:

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

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 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.

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 appeal, please contact the Appeals Department at 1-844-434-2916 (TTY: 711).

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 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 62876
Virginia Beach, VA 23466

by fax: 1-866-472-3920

Your appeal will be reviewed and a decision made within 30 calendar days for standard appeals and within 72 hours for expedited appeals. 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 1-844-434-2916 (TTY: 711). If your request does not qualify as an expedited appeal, the standard appeal process will apply.

Sources for Additional Information
If you have been unable to contact or obtain satisfaction from the Plan, you may contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 1-800-955-1819.

The Managed Care Ombudsman is available to help Virginia consumers who experience problems with, or have questions about, managed care. The Managed Care Ombudsman can assist members in understanding and exercising their rights of appeal of adverse decisions.

Write: Office of the Managed Care Ombudsman
Bureau of Insurance
PO Box 1157
Richmond, VA 23218

Phone: 1-877-310-6560 (TTY: 711)

Fax: 804-371-9944

Email: ombudsman@scc.virginia.gov

Sentara Health Plans

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's 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: ____________

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

AUTHORIZATION TO RELEASE & OBTAIN PROTECTED HEALTH INFORMATION (PHI)

(This form is for a one-time release of information to a member and/or a third party.)

SECTION A: BASIC INFORMATION *Complete with information about the subject of the health records:*

Member Name: ______________________________

Address: ______________________________

Phone Number: ______________________ Date of Birth: _____ / _____ / __________

Member ID Number: ______________________ ID Number: ______________________

SECTION B: INSTRUCTIONS FOR ACCESS *Complete to provide specifics about the access requested:*

1. What information is to be copied and released/reviewed?

☐ Claims ☐ Eligibility/Benefits ☐ Case Management/Care Coordination

(Insert dates of service for information to be released) ______________________________

I acknowledge that unless I check the following box, the information I am requesting to be used/disclosed may contain substance use disorder treatment, mental health, HIV/AIDs, or sexually transmitted infection (STI), or genetic testing information. ☐ I am NOT authorizing the release of the information listed in this paragraph.

2. How would you like the record(s) delivered?

☐ U.S. Postal Service ☐ Encrypted Email

3. Where would you like your record(s) delivered?

☐ To me (the member), at the address/email/fax listed above.

☐ To me (the member), at the following address/email/fax:

____

☐ To a third party:

Name of person/organization: ______________________________

Relationship and purpose: ______________________________

Address: ______________________________

Email: ______________________ Phone number: ______________________

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 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 the 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 health care 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 send it to Sentara Health Plans, Attention: Director of Compliance, PO Box 66189, Virginia Beach, VA 23466.

SECTION C: SIGNATURE

____ ____________
Signature of Member or Personal Representative (Ex. Guardian, Medical Power of Attorney) Date

______________________________ ______________________________
Printed Name If Signed by Personal Representative, Specify Relationship to Member

RETURN FORM (SECTIONS A, B and C COMPLETED) TO:

Sentara Health Plans
Attention: Director of Compliance
PO Box 66189
Virginia Beach, VA 23466

or email: shpprivacy@sentara.com

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.