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)

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.

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 may submit any additional information you would like to have included in the review of your appeal. New information may be submitted:

By mail: Sentara Health Plans
Appeals Department
PO Box 66189
Virginia Beach, VA 23466

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 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**.

You may also contact the U.S. Department of Labor, Pension and Welfare Benefits Administration at **1-866-444-3272** or visit their website at **www.dol.gov**.

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 to appeal an adverse decision.

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Write: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Telephone: Toll-Free: 1-877-310-6560
Richmond Metropolitan Area: 1-804-371-9032
E-Mail: ombudsman@scc.virginia.gov

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APPEAL REQUEST FORM

Today's Date: _____

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

Member's Name: _____

Subscriber's Name: _____

Address: _____

Home #: _____ Work #: _____

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

Please describe the circumstances regarding the members' request for an appeal of an adverse determination. Use additional paper if needed.

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Signature **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 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 it 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).

☐ The 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 _____