Medicare Appeal Procedure

Members or their appointed representatives (including providers) may request an appeal of an adverse benefit determination (denied authorization). Please follow the 'Filing a Pre-Service Appeal' instructions below. Providers acting on behalf of a member are encouraged to file these appeals before submitting a claim for payment.

Note: The appeal process outlined below applies before a claim is submitted for payment. **Once a claim is processed, providers should follow the Provider Reconsideration Process.**

Filing a Pre-Service Appeal

Who Can File?

- The member
- A provider or their authorized representative

When to File?

- Within 65 days from the date on the Adverse Benefit Letter (ABDL)

What to Include?

- A **written request** for appeal
- Any relevant documentation supporting the appeal (e.g., medical records, denial letters)

Types of Appeals?

- **Expedited appeals** may be requested if it's determined that following the standard processing timeframe could seriously jeopardize the members' life, health or ability to regain maximum function. Expedited appeals are resolved within **72 hours of receipt**.
- **Standard appeals** are resolved within **30 calendar days of receipt.**

How to Submit Your Appeal

Fax: 1-800-289-4970
Mail:
Sentara Medicare Appeals and Grievances
PO Box 62876
Virginia Beach, VA 23466
Hand Delivery: 1300 Sentara Park Virginia Beach, VA 23464
Email: MedicareAppeals@sentara.com
Phone Support:

- **Medicare Member Services Phone:** 1-800-927-6048
- **Medicare Appeals and Grievances Department Phone:** 1-855-813-0349

Medicare Appeal Procedure

What Happens Next

- An appeals coordinator reviews the case, gathering all necessary documentation.
- A decision is issued:
  - **Expedited:** within 72 hours
  - **Standard:** within 30 calendar days
  - **Part B:** within 7 business days
- Written notice of the decision will be sent within 10 business days of the decision.
- Once this decision is communicated, Sentara's internal appeal process is complete.

Expedited Appeals Process

Expedited appeals are available for urgent care preservice requests, when delays could:

- Seriously jeopardize the member's life, health, or ability to regain maximum function
- Cause severe pain that cannot be managed without immediate treatment

How to Request?

Include "Expedited Appeal" in the request and submit it using the following methods:

- **Phone:** Call the member services number on the back of the member's ID card.
- **Fax:** 1-800-289-4970
- **Mail:** Address listed above

What to Expect

- Decision within **72 hours** of receipt, or sooner if all necessary information is received
- Cancer-related pain medication appeals are decided within 24 hours
- If approved, notice will be given immediately (orally/electronically) and followed by written notification within 3 days