Sentara®
Health Plans

PO Box 66189
Virginia Beach, VA 23466

Dear Medicaid Member,

Thank you for your request for information regarding the Sentara Health Plan complaint process. Please refer to your member materials for a detailed description of the Plan's complaint and appeals process.

Enclosed you will find the following information to help guide you should you choose to file a complaint:

- Complaint Form
- Designation Authorization Form (to appoint someone such as a physician or family member to act on your behalf in filing a complaint or appeal)
- Authorization to Release & Obtain Protected Health Information (PHI) (this is needed so the Plan can assist you in obtaining pertinent medical information from practitioners or providers)

You may submit a complaint at any time. Please send the completed Complaint Form and any additional information related to your concerns to:

Mail: Sentara Health Plans
Appeals Department
PO Box 62876
Virginia Beach, VA 23466-2876
Fax: 1-866-472-3920

You will be notified in writing within five (5) business days that your information was received and the time required to research your concerns. Procedures for handling complaints and the associated time frames for resolving complaints will vary by the type of complaint received.

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

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Complaint 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:
Date(s) of Service:	Provider/Facility:	
Describe the circumstances regarding your complaint. Use additional paper if needed.		

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

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.