{MCO logo}

Appeal Rights

You can request an **APPEAL** if <MCO> deny, decrease, or end service(s) or supply(ies) than you and/or your health care provider thinks you need. The requested service (s) and/or supply(ies) must be medically necessary. You have a right to appeal our decision. The appeal process is a way to ask that requested service(s) and/or supply(ies) be allowed, continued, or extended. It means that you do not agree with <MCO's> decision.

Internal Appeal

You can ask for an appeal through <Entity Name> about the requested service(s), supply(ies) and/or coverage decision(s)that were denied. You must ask for an appeal within sixty (60) calendar days of our decision to deny a service or supply. Your provider can also contact <Entity/Dept> to talk to one of our providers about your denial.

You can ask for an appeal in writing, in person<MCO Address>, or by calling <Entity Name/Dept>.

Send writtenappeals to:

<Entity name>
Attention: <Grievance and Appeals>
<address>
<address> or
<Fax #, if available> or
<email address, if available>

We will let you know that we received your request for an appeal within five (5) calendar days. Call <Entity Name/Dept> if you have any questions about the appeal process. Qualified health care professionals review requests for appeals about medical issues. We will make a fair decision about your appeal within thirty (30) calendar days of receiving your appeal request.

You Have a Right…

- You have a right to ask for and get copies of all documents related to your appeal at no cost to you. You and/or your healthcare provider may add information about the appeal to your file in writing or in person. <InsertNCQA requirements, if appropriate>.
- You have a right to continue to have the currently approved service and/or supply while your appeal is under review. To have these services continue, you must call or tell us within ten (10) calendar days of the date on this letter. If your appeal is denied, you may have to pay for the cost of any continued benefits you received during the

appeal process. If your appeal is approved and you did not request services be continued while your appeal was being decided, we will authorize or provide requested services within seventy-two (72) hours of appeal decision.

- You have a right to a fast (expedited) appeal if your provider feels a delay in receiving services(s), supply(ies) or treatment(s) might be harmful, a risk to your life or cause you severe pain. You or whoever you ask to represent you should call <Entity Name/Dept> to request a fast (expedited) appeal. We will decide about your fast (expedited) appeal within seventy-hour (72) hours of receiving your request. If we deny your request for a fast (expedited) appeal, <MCO> will notify you. You have a right to file a **GRIEVANCE** if you disagree.
- If more information is needed, <MCO> will call you within two (2) calendar days to let you know that we need more time to review your appeal. We may extend our review time for up to fourteen (14) calendar days. If you disagree with our decision to take more time, you may file a Grievance with us. If wedeny your request for a fast appeal, we will answer your appeal within 30 calendar days.

Can Someone Else Appeal for Me?
Yes, your provider, lawyer, or someone else you authorize can ask for an appeal for you. First, fill out an *Authorized Representative Form*. You can get the form from <Entity Name/Dept/website> or call <MCO #>. We must complete form before we can talk to the person you've asked to handle your appeal. The *Authorized Representative Form* is good for one year from the date you sign it.

External Appeal/Review f you disagree with the appeal decision from <Entity Name>, you can ask for an external appeal through an Independent Review Organization (IRO). External appeals are for medical reviews only. Requests for an external appeal by an Independent Review Organization must be received within four (4) months of the decision of your appeal. Call <Entity Name/Dept> for help with or instructions on how to file an external appeal.

State Fair Hearing
You also have the right to request a State Fair Hearing within one hundred and twenty (120) calendar days of the appeal decision. You must go through <MCO> internal appeal process first. If the State Fair Hearing appeal is denied, you may have to pay for the continued service(s)and/or supply(ies) you received. You may ask for an external appeal and a State Fair Hearing at the same time. To request a State Fair Hearing:

- Call 401-462-2132 (TDD 401-462-3363), after you have finished <Entity Name>'s internalprocess, or
- Fax your request to 401-462-0458, or
- Email your request to OHHS.AppealsOffice@ohhs.ri.gov or
- Mail your request to EOHHS Appeals Office, Virks Building, 3 West Road,

Cranston, RI02920.

You Can File a Complaint about the Appeals Process
You can also file a complaint at any time during the appeal process with the Office of the Health Insurance Commissioner (OHIC) through their consumer helpline:

RIREACH
1210 Pontiac Avenue Cranston, RI 02920
Telephone: 1-855-747-3224 (1-855-RIREACH)
Website:
www.rireach.org
Email:
rireach@ripin.org

How to File a Grievance
You may file a grievance at any time. A grievance is a complaint about your care or dissatisfaction about anything other than a service not being covered. Examples of a grievance include:

- Not being happy with the way we responded to your complaint.
- Our asking for more time to make an authorization decision.
- You have concerns about quality of care or services provided.
- You feel a provider, or their employee was rude, or you feel a provider did not respectyour member rights.

We will respond to your grievance within ninety (90) calendar days. Sometimes we need more information or time to decide. If we need more time, we will contact you to let you know.

You or your authorized representative can file a grievance in writing or over the phone at any time. If you want someone else to file a grievance for you, you will need to fill out an Authorized Representative form. Get this form from <Entity Name/website> and send it back to <where to send> after you filled it out. <Entity Name> must get the completed form before we can talk to the person you've to handle your grievance. The *Authorized Representative Form* is good for oneyear from the date you sign it.

Send your grievance to:
<Entity Name>
<Grievance and Appeals>
<address>
<address> or
<Fax #, if available> or
<email address, if available>

OR call <Entity Name/Dept> at <Entity Name number> <TTY> <hours of operation>.

After we receive your grievance, we may ask you for more information. We will send you a letter to let you know we received your grievance and will answer it within 90 calendar days. Filing a grievance will not affect your health plan coverage.

For more information about the appeal or grievance processes or for any additional help, pleasecontact <Entity Name/Dept> at <telephone number> <(TDD/TYY)>.

INSERT: NON-DESCRIMINATION AND 15 TAG LINE

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