



Optima Health
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876

Dear Member:

Thank you for your request for information regarding the Plan's 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);
- Release of Information (This form is used so that the Plan can assist you in obtaining pertinent medical information from practitioners or providers in which health care services have been delivered).

In order for the Plan to address your concerns, your complaint must be submitted within 180 days from the date of your concern with care, service and/or policies and procedures of the Plan. Please send the completed Complaint Form and any additional information related to your concerns to:

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876
OR
Facsimile: (757) 687-6232
Toll-free facsimile: (866) 472-3920

You will be notified in writing within 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 (757) 687-6230.



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A Member has the right to designate an authorized representative, such as a physician 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 Benefits 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 the Appeals Department.

Designation Authorization Form

Member Name: _____

Member ID: _____ Date of Birth: _____

Health Plan: Optima Health Plan (OHP) Optima Health Insurance Company (OHIC)
 Sentara Health Plans, Inc. (SHP) Sentara Family Care (SFC) FAMIS

I hereby designate:

Name	Relationship
Address	
City, State, Zip	Daytime Phone #

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.

(State date, event, or condition of expiration) _____

Signed _____ Date: _____

Authorization to Disclose Protected Health Information

I hereby authorize

To release to

Specific person/class of persons/organization

Specific person/class of persons/organization

Address

Address

City, State, Zip

Phone #

City, State, Zip

Phone #

Information contained in the member file of:

Name of Member

Date of Birth

Member ID Number

Date(s) of Service

For the specific purpose of: (If you do not wish to state a purpose please state "At the request of the individual.") _____

Specific Information Requested (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Claim(s) Data (Member Profile) | <input type="checkbox"/> Problem list |
| <input type="checkbox"/> Diagnostic Studies | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> List of Allergies |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Most Recent History and Physical |
| <input type="checkbox"/> Lab or X-ray data | <input type="checkbox"/> Most Recent Discharge Summary |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress / Clinical Record | <input type="checkbox"/> Psychiatric & Psychological Information |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Other _____ |

I understand that by signing this form I give permission to release the specific information requested designated above to the designated recipient and agree to hold both the releaser and the recipient harmless for complying with this authorization. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months. 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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that my health plan may condition my enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to my enrollment if the authorization sought is for the health plan's eligibility or enrollment determinations relating to me or its underwriting or risk rating determinations, and the authorization is not for use or disclosure of psychotherapy notes.

Complete only if Sentara requested the disclosure (circle appropriate): Sentara will/ will not receive remuneration for this disclosure

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality laws. If I have questions about disclosure of my health information, I can contact Sentara Privacy Office. 757-857-8494.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, relationship to Member

Signature of Witness