Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, Virginia 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.

OptimaHealth

COMPLAINT FORM

Today's Date: _____

Member ID #_____ Member's Name: _____

Address:_____

Home#:_____Work#:_____

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

Please describe the circumstances regarding your complaint. Use additional paper if needed.

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_____ _____

Signature **Date**

OptimaHealth

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 Optima Health Appeals Department.

Optima Health Designation Authorization Form
Appeals Department

Member Name: _____

Member ID#: _____ Date of Birth: _____

Health Plan: ☐ Optima Health Plan (OHP) ☐ Optima Health Insurance Co. (OHIC)

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.

(State date, event, or condition of expiration)

Signed _____ Date _____

OptimaHealth

Authorization to Disclose Protected Health Information

I hereby authorize:

_____
(Specific person/class of persons/organization)

_____
Address

_____
City, State, Zip Phone #

To release to:

_____
(Specific person/class of persons/organization)

_____
Address

_____
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.")

_____

Requested (check all that apply):

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

Optima Health Alternative Language Options for Notices and other Written Information

English: This Notice has Important Information. This notice has important information about your application or coverage through Optima Health. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-687-6260.

Amharic:
ይህ ማስታወቂያ ጠቃሚ መረጃ አለው። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም በOptima Health በኩል ስለሚኖርዎት ሽፋን ጠቃሚ መረጃ አለው። በዚህ ማስታወቂያ ላይ ያሉትን ቁልፍ የሆኑ ቀናቶችን ያስተውሉ። የጤና ሽፋንዎትን ለማስቀጠል ወይም ወጪዎትን ለማገዝ እንዲቻል በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ሊያስፈልግዎ ይችላል። በራስዎ ቋንቋ ያለምንም ክፍያ ይህን መረጃም ሆነ ድጋፍ የማግኘት መብት አለዎት። 1-855-687-6260 ይደውሉ።

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. يحتوي هذا الإخطار على معلومات مهمة تتعلق بطلبك أو ببرنامج التغطية الخاص بك لدى شركة التأمين الصحي Optima Health. ابحث عن التواريخ الرئيسية في هذا الإخطار، فقد تحتاج إلى اتخاذ أي إجراء قبل حلول المواعيد النهائية للحفاظ على برنامج التغطية الصحية أو الحصول على مساعدة في التكاليف. ولديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك بدون أي تكلفة. يُرجى الاتصال 1 -855-687-6260

Bengali/Bangla:
এই বিজ্ঞপ্তিতে রত্বপূণ তথ রেয়েছ। এই প্রজ্ঞাপেন Optima Health (অিপ্টমা হেলথ)-এর মাধমে দাখিল করা আপনার দরখাস্ত বা কভাের্জর উপর পূণ তথ রেয়েছ। এই বিজ্ঞপ্তিতে

উেল্লখ করা পূণ তারিখগুো দেখ নিন। আপনার হেলথ কভারেজ বজায় রাখার জন বা খরেচর বিষেয় সহায়তা লাভের জন আপনাকে িনিদ ষ্ট সময়সীমার মেধ ব বস্থা গ্রহণ করেত হেত পারে। বিনা খরেচ আপনার মাতৃভাষায় এই তথ এবং সহায়তা পাওয়ার অিধকার আপনার রেয়েছ। কল 1-855-687-6260.

Chinese (Mandarin):
该通知含有重要信息。本通知含有关于 Optima Health 申请或保险的重要信息。请仔细查看本通知中的关键日期。您需要在截止期之前采取相应的行动，从而保障您的保险继续有效，能够为您提供报销。您有权免费获取信息的中文版，并可以免费获取到相关的中文帮助。請撥電話 1-855-687-6260.

French: Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Optima Health. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-855-687-6260.

German: Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Optima Health. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-855-687-6260.

Hindi:
इस सूचना में महत वपूणर जानकारी िनिहत है। इस सूचना में Optima Health के माध यम से आपके आवेदन या कवरेज के बारे में महत वपूणर जानकारी िनिहत है। इस सूचना में िनिहत महत वपूणर ितिथयों को देखें। आपको लागत के साथ अपने स वास्थ य का कवरेज रखने या सहायता के लिए िनिश्चत समय सीमा में काररवाई करने की जरूरत हो सकती है। आपके पास बिना किसी लागत के अपनी भाषा में इस जानकारी और सहायता को प्राप्त करने का अधिकार है। कॉल 1-855-687-6260

Ibo: **Ọkwa a nwere Ozi Dị Mkpa.** Ọkwa a nwere ozi dị mkpa maka akwụkwọ anamachọihe ma ọ bụ mkpuchi gị sitere na Optima Health (Ahụike Optima). Chọọ ụbọchị ndị dị mkpa n'ọkwa a. Ị nwere ike ịme ihe tupu ụfọdụ ụbọchị iji dowe mkpuchi ahụike gị ma ọ bụ enyemaka n'ụgwọ. Ị nwere ike ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Kpọ 1-855-687-6260

Korean: 이 공지는 매우 중요한 정보입니다. 이 공지는 옵티마 헬스를 통한 귀하께 적용되는 지원이나 보험에 대한 매우 중요한 정보입니다. 이 공지의 주요 날짜를 찾아보십시오. 귀하께서는 귀하의 건강 보험이나 비용에 관한 도움에 관련된 특정 마감일을 지켜야만 합니다. 귀하께서는 따로 비용없이 귀하의 언어로 이 정보와 도움을 받을 권리가 있습니다. 로 전화하십시오 1-855-687-6260.

Kru/Bassa: Náùm pò wùdù nà kɛ̀ kpà dɛ̀ mìù. Ɔ mɔ̀ɔ dɛ̀ kpà dɛ ɓá nì dyí kánà-kánà dyì dé Optima Health mú. Mɔ̀ tì kpà dɛ̀ ɓè nì dé náùm pò wùdùɔ̀ mú. Mɔ̀ tì kpà dɛ̀ ɓè nì dé náùm pò wùdùɔ mú. Mɔ̀ ɓè dé ɓɛ̀ mɔ̀ ké náùm pò pòɔ̀ ɔ̀ mù pó dyì. Ɔ̀ jù kè mɔ̀ dyì dɛ ɓɛà nyùɛ̀n, mɔ̀ wídí̩ɔ̀ mù ɓì dì̩ dyì. Wà ɓì dì̩ ɓɛ̀ wà kè náùm pó wùdù nà kɛ̀ Bàsɔ̀ wùdù mù pò. Sebel 1-855-687-6260.

Navajo: Díí saad íliinii baa hane'. Naaltsoos·ni'íníłtsoozígíí éí doodago kwe'é Optima Health nik'é'ésti'ígíí bína'ídíłkidgo díí kwe'é hazhó'ó baa ákonínízin dooleeł. Yoołkáał yę́ędą́ą́' nich'į' é'élyaago biká'ígíí hádídíí'įįł. Díí niké'ésti'ígíí éi doodago béeso da bee níká a'doowołígíí bikáa'go da áť'ée dooleeł áko t'áadoo bee e'e'aahí baa yíłkaahgo tsxį́įłgo hasht'e díílííł níi da dooleeł. Bee haz'áanii hóló díí kót'éego yaa halne'ígíí bee níká a'doowołgo dóó t'áá nizaadk'ehjí bee nił hodoonih t'áadoo bą́ą́h ílíní. 'Átah ánǫ́t'i'ígíí bee baa 'áháyą́ ągéé bich'į' bibéésh bee hane'í hwéédilní. 1-855-687-6260.

Persian/Farsi:
این اعلامیه حاوی اطلاعات مهمی است. این اعلامیه حاوی اطلاعات مهمی درباره درخواست شما و پوشش Optima Health است. به تاریخ های کلیدی عنوان شده در این اعلامیه دقت کنید. ممکن است لازم باشد تا یک تاریخ مقرر خاص اقدام کنید تا پوشش بیمه تان حفظ شود یا در رابطه با هزینه ها به شما کمک شود. شما از این حق برخوردار هستید تا این اطلاعات و هرگونه راهنمایی دیگر را به زبان خودتان و به صورت رایگان دریافت کنید. 1-855-687-6260

Russian: В данном уведомлении содержится важная информация. В данном уведомлении содержится важная информация о Вашей заявке или страховом покрытии в компании Optima Health. Обратите внимание на важные даты, указанные в данном уведомлении. Если Вы хотите продолжать пользоваться мед.страхованием или получить помощь с оплатой, возможно, Вам потребуется принять решение до определенной даты. У Вас есть право на бесплатное получение данной информации и помощи на родном языке. Звоните по телефону 1-855-687-6260.

Spanish: Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Optima Health. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-855-687-6260.

Tagalog: Ang Paunawang Ito ay Naglalaman ng Mahalagang Impormasyon. Ang paunawang ito ay naglalaman ng mahalagang impormasyon tungkol sa inyong aplikasyon o saklaw sa pamamagitan ng Optima Health. Hanapin ang mahahalagang petsa na nakasaad sa paunawang ito. Maaaring kailanganin ninyong gumawa ng hakbang bago sumapit ang ilang partikular na takdang petsa upang mapanatili ang inyong saklaw na pangkalusugan o tulong sa mga gastusin. Mayroon kayong karapatan na matanggap ang impormasyong ito at makakuha ng tulong sa inyong wika nang walang bayad. Tumawag sa 1-855-687-6260.

Urdu:
اس نوٹس میں اہم اطلاع موجود ہے۔ اس نوٹس میں آپ کی درخواست یا Optima Health کے ذریعے کوریج کے حوالے سے اہم اطلاع موجود ہے۔ اس نوٹس میں درج کلیدی تاریخوں کو ذہن میں رکھیں۔ آپ کے لیے ضروری ہے کہ مخصوص ڈیڈلائنوں سے قبل اس حوالے سے کوئی ایکشن لیں تاکہ آپ کی کوریج برائے صحت اور لاگت کے حوالے سے معاملات طے رہیں۔ آپ اس اطلاع تک رسائی اور بغیر کسی خرچ کے اپنی زبان میں اس بابت جاننے 1 -855-687-6260

Vietnamese: Thông báo này có thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc về bảo hiểm của quý vị thông qua Optima Health. Quý vị hãy xem những ngày quan trọng trong thông báo này. Quý vị có thể cần đưa ra hành động trước ngày hết hạn cụ thể để duy trì bảo hiểm sức khỏe của quý vị hoặc hỗ trợ thanh toán cho các chi phí. Quý vị có quyền nhận được thông tin và sự hỗ trợ này theo ngôn ngữ mà quý vị muốn mà không phải trả thêm chi phí nào. Xin gọi số 1-855-687-6260.

Yoruba: Àkíyèsí yìí ní Àlàyé Pàtàkì. Àkíyèsí yìí ní àlàyé pàtàkì nípa ohun tí o bèèrè fún tàbí gbígbà ìtọ́jú nípasẹ̀ Optima Health. Wo àwọn ọjọ́ tó ṣe kókó nínú àkíyèsí yìí. O lè nílò láti gbé ìgbésẹ̀ nípa gbèdéke kan láti ṣètọ́jú ìlera rẹ tàbí ṣèrànw ọ́ nípa iye òwó. O ní ẹ̀tọ́ láti gba àlàyé yìí àti ìrànwọ́ yìí ní èdè rẹ láìsan owó. Pè sórí 1-855-687-6260.