OptimaHealth

FILING AN APPEAL FOR COVERAGE OF MEDICAL CARE THAT HAS BEEN DENIED BY OPTIMA MEDICARE HMO

If your request for coverage or payment for a medical item or service has been denied, you can file an appeal with Optima Medicare by completing and returning the Optima Medicare HMO Medical Care Appeal Request Form below. More information about the Optima Medicare medical appeal process is included below and also in your Optima Medicare Evidence of Coverage.

If you have questions about the appeal process, you can call the Optima Medicare Appeals Coordinator at 757-687-6230. You can also call us toll-free through our Optima Medicare Member Services line at 1-800-927-6048. TTY users should call the Virginia Relay Service at 1-800-828-1140 or 711. A Member Services Representative can transfer you to the Medicare Appeals Coordinator and also assist you with general questions about complaints at the following times.

- From October 1 - February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET.
- From February 15 - September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET.

To file an appeal, you must do so within 60 days of the date on the letter about our initial decision. We may give you more time if you have a good reason for missing this deadline.

If you need someone to act on your behalf to file an appeal, that person must either have legal authority or be appointed as a designated representative. If someone has legal authority, such as a Durable Power of Attorney or is a court appointed guardian, etc., a copy of this legal document must be sent to us. To have a relative, friend, attorney, doctor, or someone else be appointed as your designated representative, both you and this person must complete, sign, and return the Appointment of Representative Form.

A **standard appeal** will be reviewed and a decision made within 30 calendar days of the date your appeal is received for medical care you have not received and within 60 days for care you have already received.

Please mail or fax the completed Optima Medicare HMO Medical Care Appeal Request (or a letter explaining why you think the Plan's decision was incorrect), legal representation documentation or Appointment of Representative Form (if either is needed), and any additional information about your appeal to:

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876
OR
Fax: 757-687-6232
Toll-free Fax: 1-866-472-3920

You, your doctor or your representative can decide if you need to file a **fast appeal** for care you have not received yet. **Call us** at the phone numbers above to file a fast appeal. If your doctor calls us or provides a written statement to us to explain that you need a fast appeal due to your health, we will automatically give you a fast decision within 72 hours. If you file a fast appeal without support from a doctor, we will decide if your health requires a fast decision.

With your appeal request, you or your doctor should also send us any information we did not have when we made our initial decision on your request for coverage for a medical item or service such as:

- Office notes from physicians that you have seen regarding the services or procedures in question;
- Medical records from hospitals and other health care providers;
- Physician correspondence;
- Physical, occupational, or rehabilitative therapy notes;
- Copies of bills you have received;
- Any additional information you would like the Plan to consider in reviewing your appeal.

If you have difficulty in obtaining information from your provider, please contact the Appeals Department for assistance at one of the above phone numbers.

For more information and help in handling an appeal, you can contact Medicare.

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, Virginia 23466-2876

OPTIMA MEDICARE HMO MEDICAL CARE APPEAL REQUEST FORM

Today's Date: _____

Member ID #_____Group Number: _____ Name of Plan: _____

Member's Name: _____

Address:_____

Home #:_____ Work #:_____

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

Please clearly describe the circumstances regarding your request for an appeal of coverage or payment for a medical item or service that we denied. Use additional paper, if needed.

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SIGNATURE DATE