OPTIMA COMMUNITY COMPLETE (HMO SNP)

HOW TO MAKE A COMPLAINT,
REQUEST A COVERAGE DECISION,
OR
FILE AN APPEAL
ABOUT COVERED MEDICARE
MEDICAL CARE AND SERVICES
OR
COVERED PRESCRIPTION DRUGS

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DEFINITIONS OF COMPLAINTS, COVERAGE DECISIONS, AND APPEALS

A complaint is a problem or concern you have about something such as:

- The service you receive from your plan's Member Services.
- You feel that you are being encouraged to leave (disenroll from) your plan.
- Your plan doesn't give you a decision within the required time frame or give you the required notices.
- Your Medicare plan doesn't forward your case to the Independent Review Organization if your plan does not give you an appeal decision on time.
- The quality of the covered medical care or prescription drugs you receive, including quality of care during a hospital stay.
- How long you have to wait on the phone, in the waiting room or the exam room, or for prescriptions to be filled.
- Getting doctor appointments when you need them or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, pharmacists or other staff.

A coverage decision is a decision your plan makes about your benefits and coverage or about the amount your plan will pay for your medical services or prescription drugs. The following situations are coverage decision examples:

- Your network doctor recommends a procedure or piece of medical equipment or prescription drug that requires prior authorization from your plan. Your plan will review the request and determine if it is a covered benefit and medically necessary.
- You or your doctor contact your plan to ask for a coverage decision if your doctor is unsure whether the plan will cover a particular medical service or prescription drug.
- You are not getting certain medical care or services you want, and you believe that this care is covered by your plan.
- Your plan makes a coverage decision whenever it decides what is covered and how much it will pay, if applicable.
- You ask your plan to pay for a medical service or prescription drug you have already received.
- You are being told that medical care you are getting will be reduced or stopped, and you believe that this could harm your health.

If your plan makes a coverage decision and you are not satisfied with this decision, you can file **an appeal** of our decision. An appeal is a formal way of asking your plan to review and change a coverage decision it made.

OPTIMA COMMUNITY COMPLETE COMPLAINTS, COVERAGE DECISIONS, AND APPEALS

WHO MAY MAKE A COMPLAINT, REQUEST A COVERAGE DECISION OR FILE AN APPEAL?

You or someone you choose may make a complaint, request a coverage decision, or file an appeal for Part C medical care or services or Part D prescription drugs. You may choose a relative, friend, lawyer, advocate, doctor, or someone else to act for you as your appointed representative. Other persons may already be authorized under State law to act for you. If you want to appoint someone to

act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. Your doctor can request a coverage decision or a Level 1 Appeal on your behalf.

To appoint a representative, you and the person accepting the appointment must complete and sign an *Appointment of Representative* form or a written notice with all of the same information and send it to us. You can also call Member Services at 1-800-927-6048 (TTY Virginia Relay Service at 1-800-828-1140 or 711) and we will send this form to you.

For medical and prescription drug complaints and medical coverage decisions and appeals, mail or fax the completed and signed *Appointment of Representative* form or written notice to:

Optima Community Complete
Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232 or Toll-free Fax: 1-866-472-3920

For prescription drug coverage decisions and appeals, mail or fax the completed and signed *Appointment of Representative* form or written notice to:

OptumRx
Attn: Prior Auth Part D Exceptions
P.O. Box 5252
Lisle, IL 60532
Fax: 1-866-511-2202

HOW TO MAKE A COMPLAINT ABOUT COVERED PART C MEDICAL CARE AND SERVICES OR COVERED OUTPATIENT PART D PRESCRIPTION DRUGS

You can always speak to one of our Optima Community Complete Member Services Representatives about a complaint, coverage decision, or appeal. Member Services can be reached at 1-800-927-6048. TTY users can call the Virginia Relay Service at 1-800-828-1140 or 711.

Calls to these numbers are free. From October 1 through February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET. From February 15 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Outside of these times, our interactive voice response system allows you to obtain information on many topics related to your plan. If you need more information, you can leave a message including your name, phone number, the time you called, and your questions. A Member Services Representative will return your call the next business day.

You can also call Medicare for help with a complaint, coverage decision, or an appeal as follows:

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

More information about making a complaint, requesting a coverage decision, or making an appeal is included later in this document.

Making a complaint

If you have a complaint, you or your representative should call or write to Optima Community Complete Member Services at 1-800-927-6048 (TTY call the Virginia Relay Service at 1-800-828-1140 or 711) as soon as possible but at least within 60 days of the occurrence. If you call us, we will

try to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we will thoroughly review your complaint and notify you once we complete our review. You can also send us a written complaint.

If you want to send us a written complaint or you called and were not satisfied, you can mail or fax your complaint to us at:

Optima Community Complete
Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232 or Toll-free Fax: 1-866-472-3920

Making a Fast Complaint

You can file a fast complaint if:

- You asked for a fast coverage decision for a service or drug, and we decided to process it under our standard (non-expedited) time frame. We will give you a fast decision if you resubmit it with a supporting medical statement from your doctor.
- We said we need up to 14 more days to decide on your coverage decision or appeal for a service or drug.

You Can Tell Medicare about Your Complaint

To submit a complaint about Optima Community Complete directly to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. You can also call Medicare 24 hours a day/7 days a week at 1-800-MEDICARE. TTY/TDD users can call 1-877-486-2048.

Quality of Care Complaints and Complaints about Certain Medical Services You think are Ending too Soon

If you have a complaint about the quality of care you have received, if you think your hospital stay is ending too soon, or you think your home health care, skilled nursing facility or Comprehensive Outpatient Rehabilitation Center services are ending too soon, you can contact KEPRO. This organization is a group of practicing doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. KEPRO is an independent organization and is not connected with our plan. To file a complaint with KEPRO, send it to:

KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Phone: 1-844-455-8708

HOW TO REQUEST A COVERAGE DECISION FOR COVERED PART C MEDICAL CARE AND SERVICES

A coverage decision is a decision Optima Community Complete makes about benefits and coverage or about the amount we will pay for medical care. The decision we make to approve or disapprove a test your doctor wants you to have that requires prior authorization from us in advance is a coverage decision. If you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

Asking us to pay for a covered medical service you have already received is a type of coverage decision. The Optima Community Complete Evidence of Coverage has information on how to request that we pay you back for a covered medical service that you have already paid for and received.

To ask for a coverage decision for Part C medical care or service, you, your doctor, or your representative should call, fax or write to us at the following:

Optima Community Complete
Medical Care Services
4417 Corporation Lane
Virginia Beach, VA 23462
1-800-927-6048
TTY: Virginia Relay Service 1-800-828-1140 or 711
Fax: 757-552-8844 (local) or 1-844-251-5977 (toll-free)

Asking for a fast coverage decision

You may ask for a fast coverage decision if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says if you get a doctor's support for a fast decision, we will automatically give you one. The letter will also tell you how to file a fast complaint. You have the right to file a fast complaint if you disagree with our decision to deny your request for a fast coverage decision. See the section on "Fast Complaints" earlier in this document for details. If we deny your request for a fast decision, we will give you a standard decision.

HOW TO FILE AN APPEAL ABOUT COVERED PART C MEDICAL CARE & SERVICES

If you do not agree with the coverage decision we made about your Part C Medical Services, you, your doctor, or representative may file an appeal with us. The appeal must be filed within 60 days from the date included on the letter about our coverage decision. We may give you more time if you have a good reason for missing the deadline.

To file a standard appeal about Part C medical care or services, send or fax a signed, written appeal to:

Optima Community Complete
Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232 or Toll-free fax: 1-866-472-3920

Filing a fast appeal

If you want to appeal a decision we made about giving you Part C medical care or services that you have not received yet, you, your doctor or your representative can decide if you need to file a fast

appeal. You can file a fast appeal by calling, faxing, or writing us at:

Optima Community Complete
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
Phone: 757-687-6404 or Toll-free Phone: 1-800-927-6048
TTY: Virginia Relay Service at 1-800-828-1140 or 711
Fax: 757-687-6232 or Toll-free Fax: 1-866-472-3920

You can also file a fast appeal for Part C medical care or services outside of regular weekday business hours. Please call the Optima Health Appeals Department at 757-687-6404 and leave a detailed message. Your call will receive priority attention the next business day. Be sure to ask for a "fast" or "72-hour" decision.

If your doctor provides a written or oral supporting statement explaining that you need a fast appeal due to your health, we will automatically give you a fast decision. If you file a fast appeal without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast appeal, we will send you a letter informing you that if you get a doctor's support for a fast appeal, we will automatically give you a fast decision.

HOW TO REQUEST A COVERAGE DECISION FOR COVERED OUTPATIENT PART D PRESCRIPTION DRUGS

A coverage decision is a decision Optima Community Complete makes about your benefits and coverage or about the amount we will pay for your Part D drugs. If you want to know if we will cover a Part D drug before you receive it, you can ask us to make a coverage decision.

Asking us to pay for a prescription drug you have already received is a type of coverage decision. The Optima Community Complete Evidence of Coverage has information on how to request that we pay you back for a covered Part D drug that you have already paid for and received.

An exception is a type of coverage decision involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in different situations.

- You may ask us to cover a Part D drug even if it is not on our formulary (drug list).
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example:
  - For certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more.
  - Since you must receive prior authorization from us before you can get certain covered drugs, you can ask us to waive this requirement.
  - You could ask us to waive the step therapy requirement for a certain drug. This means you wouldn't have to try a proven, less expensive drug before using a more expensive one.

Your doctor must submit a statement supporting your exception request. To help us make a decision more quickly, the medical information from your doctor should be sent to us with the exception request. If we approve your exception request, our approval is valid for the rest of the Plan calendar year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an

exception to the copay amount we require you to pay for the drug.

To ask for a standard coverage decision for a Part D drug, you, your doctor, or your representative can call (24-hours a day, 7 days a week), fax, or send OptumRx a written request or the completed form located on our website at www.optimahealth.com/communitycomplete. You can call Optima Community Complete Member Services (contact information is on page 2 of this document) and we will send this form to you. Call, mail or fax your written request or the completed form to:

OptumRx
Attn: Prior Auth Part D Exceptions
P.O. Box 5252
Lisle, IL 60532
Phone: 1-866-603-17514; TTY: 711
Fax: 1-866-511-2202

Asking for a fast coverage decision

You may ask for a fast coverage decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision. You cannot get a fast decision if you are asking us to pay you back for a Part D drug that you already received.

HOW TO FILE AN APPEAL ABOUT COVERED OUTPATIENT PART D PRESCRIPTION DRUGS

If you do not agree with the coverage decision we made about your Part D drug, you may file an appeal. The appeal must be filed within 60 days from the date included on the letter about our coverage decision. We may give you more time if you have a good reason for missing the deadline.

To ask for a standard appeal about a Part D drug, send or fax a signed, written appeal to:

OptumRx
Attn: Part D Appeals
P.O. Box 5252
Lisle, IL 60532
Fax: 1-866-511-2202

Filing a fast appeal

If you want to appeal a decision we made about giving you a Part D drug that you have not received yet, you or your doctor need to decide if you need a fast appeal. You, your doctor, or your representative may file a fast appeal by calling, faxing, or writing:

OptumRx
Attn: Part D Appeals
P.O. Box 5252
Lisle, IL 60532
Phone: 1-866-4603-7514 / TTY: 711
Fax: 1-866-511-2202

If your doctor provides a written or oral statement explaining that you need a fast appeal due to your health, we will automatically give you a fast appeal. If you ask for a fast appeal without support from a

doctor, we will decide if your health requires a fast appeal. If we decide that your medical condition does not meet the requirements for a fast appeal, we will send you a letter informing you that if you get a doctor's support for a fast appeal, we will give you one.

FOR MORE INFORMATION

You can find more information about any of these processes in the Evidence of Coverage (EOC) for your Optima Community Complete Plan. The EOC also includes additional appeal steps that can be taken if you are not satisfied with the result of your appeal with Optima Community Complete.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PLAN COMPLAINTS AND APPEALS

HOW TO MAKE A COMPLAINT

You should contact your Commonwealth Coordinated Care Plus (CCC Plus) (Medicaid) plan to make a complaint about your Medicaid benefits. Information about how to do this should be in the Member Handbook you received from your plan and also on their website.

Timeframe for Complaints
You can file a complaint with your CCC Plus plan within 180 days from the date of the concern or issue.

Authorized Representative
You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform your CCC Plus plan of the name of your authorized representative. Call the Member Services Department at your CCC Plus plan for help with naming an authorized representative.

There Are Different Types of Complaints
You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by your CCC Plus plan. An external complaint is filed with and reviewed by an organization that is not affiliated with your CCC Plus plan.

Internal Complaints
To make an internal complaint, call or send a letter to your CCC Plus plan. If you put your complaint in writing, your plan will respond to your complaint in writing. You can file a complaint in writing, by mailing or faxing it to your plan. So that your CCC Plus plan can best help you, include details on who or what the complaint is about and any information about your complaint. Your plan will review your complaint and additional information, if needed. You can call Member Services at your plan if you need help filing a complaint or if you need assistance in another language or a different format.

If Optima Health Community Care is your CCC Plus (Medicaid) Plan and you have a complaint
If your CCC Plus Medicaid plan is Optima Health Community Care, you can make a complaint by calling, sending a letter or a fax as follows:

Optima Health Community Care
Attn: Appeals Department
4417 Corporation Lane
Virginia Beach, VA 23462

Phone: 1-888-512-3171; TTY: 1-844-552-8148
Fax: 1-800-881-2166

External Complaints

You Can File a Complaint with the CCC Plus Helpline

You can make a complaint about your Medicaid plan to the CCC Plus Helpline. Contact the CCC Plus Helpline at 1-844-374-9159 or TTY 1-800-817-6608.

You Can File a Complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. You can also visit http://www.hhs.gov/ocr for more information.

You may contact the local Office for Civil Rights office at:
Office of Civil Rights- Region III
Department of Health and Human Services
150 S Independence Mall West Suite 372
Public Ledger Building
Philadelphia, PA 19106
1-800-368-1019
Fax: 215-215-861-4431
TTY: 1-800-537-7697

You Can File a Complaint with the Office of the State Long-Term Care Ombudsman

The State Long-Term Care Ombudsman serves as an advocate for older persons receiving long-term care services whether the care is provided in a nursing facility or assisted living facility, or through community-based services to assist persons still living at home. Local Ombudsmen provide older Virginians and their families with information, advocacy, complaint counseling, and assistance in resolving problems with CCC Plus plans or for long-term care issues. Their services are free.

Office of the State Long-Term Care Ombudsman
Virginia Office of the State Long-Term Care Ombudsman
Virginia Department for Aging and Rehabilitative Services
8004 Franklin Farms Drive
Henrico, Virginia 23229
804-662-9140 or toll-free 1-800-552-5019.
TTY: 1-800-464-9950
This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
http://www.ElderRightsVA.org

HOW TO FILE AN APPEAL

Adverse Benefit Determination

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. A decision made by your Commonwealth Coordinated Care Plus (CCC Plus) (Medicaid) plan to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination.

You have the right to appeal any adverse benefit determination made by your CCC Plus plan that you disagree with that relates to coverage or payment of your Medicaid services. For example, you can appeal if your CCC Plus plan denies:

- A request for a health care service, supply, item or drug that you or your provider thinks you should be able to get, or
- A request for payment of a health care service, supply, item, or drug.

You can also appeal if your CCC Plus plan stops providing or paying for all or a part of a service or drug you receive through CCC Plus that you think you still need.

Authorized Representative
You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform your CCC Plus plan of the name of your authorized representative. Call the Member Services Department at your CCC Plus plan for help with naming an authorized representative.

How to Submit Your Appeal
If you are not satisfied with a decision your plan made about your service authorization request, you have 60 calendar days after hearing from your plan to file an appeal. You can do this yourself or ask your authorized representative file the appeal for you. You can call Member Services at your CCC Plus plan if you need help filing an appeal or if you need assistance in another language or require an alternate format. You will not be treated unfairly because you file an appeal.

You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request. If you send your standard appeal by phone, it must be followed up in writing. Expedited appeals submitted by phone do not require you to submit a written request.

You or your doctor can ask to have your appeal reviewed under the expedited process if you believe your health condition or your need for the service requires an expedited review. Your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied we will tell you and your appeal will be reviewed under the standard process.

Continuation of Benefits
In some cases, you may be able to continue receiving services that were denied by your CCC Plus plan while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within 10 days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements explained here.

What Happens After We Get Your Appeal
Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can send information to your CCC Plus plan that you want to be used in making the appeal decision in person or in writing. Contact your plan if you want to do this.

Timeframes for Appeals
Standard Appeals
If your plan has all the information it needs, your plan is to tell you its decision within 30 days of when it received your appeal request. Your plan will tell you within 2 calendar days after receiving your appeal if it needs more information. A written notice of the decision will be sent within 2 calendar days from when the decision is made.

Expedited Appeals
If your CCC Plus plan has all the information it needs, expedited appeal decisions will be made within 72 hours receipt of your appeal. It will tell you within 2 calendar days after receiving your appeal if it needs more information. Your plan will tell you its decision by phone and send a written notice within 2 calendar days from when the decision is made.

If Your CCC Plus Plan Needs More Information
If your plan can't make the decision within the needed timeframes because it needs more information it will:

- Write you and tell you what information is needed. If your request is in an expedited review, your plan will call you right away and send a written notice later;
- Tell you why the delay is in your best interest; and
- Make a decision no later than 14 *additional days* from the timeframes described above.

You, your provider, or someone you trust may also ask your CCC Plus plan to take more time to make a decision. This may be because you have more information to give your plan to help decide your case. Your plan may extend the timeframe by up to an additional 14 calendar days if you request an extension or if the plan provides evidence satisfactorily to DMAS that a delay in making the decision in your best interest.

You or your authorized representative can file a complaint with your plan if you do not agree with the plan's decision to take more time to review your appeal. You or you representative can also file a complaint about the way your CCC Plus plan handled your appeal to the State through the CCC Plus Help Line at 1-844-374-9159 or TTY 1-800-817-6608.

If your plan does give you a decision about your appeal on time, you have the right to appeal to the State through the State Fair Hearing process. An untimely response by your CCC Plus plan is considered a valid reason for you to appeal further through the State Fair Hearing process.

Written Notice of Appeal Decision
Your plan will tell you and your provider in writing if your request is denied or approved in an amount less than requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. Your plan will explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

Authorized Representative
You can give someone like your PCP, provider, or friend or family member written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

If Optima Health Community Care is your CCC Plus (Medicaid) Plan and you have an appeal.
If your CCC Plus plan is Optima Health Community Care, start your appeal by calling (for expedited (fast) appeals), sending a letter or a fax as follows:

Optima Health Community Care
Attn: Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876
Phone: 1-844-434-2916; TTY: 1-844-552-8148
Fax: 1-866-472-3920

Your Right to a State Fair Hearing
If you disagree with your CCC Plus plan's decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if your CCC Plus plan denies payment for covered services or if it does not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) your CCC Plus plan appeals process before you can file an appeal request through the State Fair Hearing process. If your plan does not respond to your appeal request timely, DMAS will count this as an *exhausted appeal*.

An appeal may be filed at any time after the plan's appeal process is exhausted and extending through 120 calendar days after receipt of the plan's final adverse benefit determination.

Standard or Expedited Review Requests
For standard requests, appeals will be heard and DMAS will give you an answer generally within 90 days from the date you filed your appeal with your CCC Plus plan. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from your doctor.

Where to Send the State Fair Hearing Request
You or your representative must send your standard or expedited appeal request to DMAS by internet, mail, fax, email, telephone, in person, or through other commonly available electronic means. Send State Fair Hearing requests to DMAS within no more than 120 calendar days from the date of our final decision. You may be able to appeal after the 120 day deadline in special circumstances with permission from DMAS.

You may write a letter or complete a Virginia Medicaid Appeal Request Form. This form is available at your local Department of Social Services or on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx. You should also send DMAS a copy of the letter your CCC Plus plan sent to you in response to your appeal.

You must sign the appeal request and send it to:
Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Fax: (804) 452-5454
Standard and Expedited Appeals may also be made by calling (804) 371-8488.

After You File Your State Fair Hearing Appeal

DMAS will notify you of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

State Fair Hearing Timeframes

Expedited Appeal

If you qualify for an expedited appeal, DMAS will give you an answer to your appeal within 72 hours of receiving the letter from your doctor. If DMAS decides right away that you win your appeal, they will send you their decision within 72 hours of receiving the letter from your doctor. If DMAS does not decide right away, you will have an opportunity to participate in a hearing to present your position. Hearings for expedited decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS still has to give you an answer within 72 hours of receiving your doctor's letter.

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will generally give you an answer within 90 days from the date you filed your appeal. You will have an opportunity to participate in a hearing to present your position before a decision is made.

Continuation of Benefits

In some cases you may be able to continue receiving services that were denied by your CCC Plus plan while you wait for your State Fair Hearing appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within 10 days from being told that your request is denied or care is changing;
- By the date the change in services is scheduled to occur.

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. **You may, however, have to repay your CCC Plus plan for any services you receive during the continued coverage period if your CCC PLUS plan adverse benefit determination is upheld and the services were provided solely because of the requirements described in this Section.**

If the State Fair Hearing Reverses the Denial

If services were not continued while the State Fair Hearing was pending

If the State Fair Hearing decision is to reverse the denial, your CCC Plus plan must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date your plan receives notice from the State reversing the denial.

If services were provided while the State Fair Hearing was pending

If the State Fair hearing decision reverses the denial and services were provided while the appeal is pending, your CCC Plus plan must pay for those services, in accordance with State policy and regulations.

If You Disagree with the State Fair Hearing Decision

The State Fair Hearing decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision you may appeal it to your local circuit court.