Optima Health Community Care
P O Box 62876
Virginia Beach, VA 23466-2876

www.optimahealth.com

Dear Optima Health Community Care Member:

Thank you for your request for information regarding the Plan's Appeal Process. You will find the following information to help you with your appeal:

- Appeal Request Form
- Appeal Procedure

To file an appeal, please send your request to:

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

You or your representative have the right to present any information related to your appeal. If you need help getting information or have questions about your appeal, please contact the Appeals Department at 757-687-6110.

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Complaint Process:

The Plan would like you to be happy with the medical care and services you receive. If you have a problem or complaint concerning the Plan, covered services, timeliness or quality of services provided, pre-authorization decisions, or assignment of PCPs, you may file a complaint so it can be resolved to your satisfaction.

To file a complaint at any time from the date of the concern or issue you may contact:

Optima Health Community Care Member Services
757-552-8360 or 1-888-512-3171
Hearing impaired members may call the TTY number:
757-552-8390 or 1-844-552-8148
Interpreter services are available, free of charge

If you have a complaint about a healthcare provider, you may call Member Services or you may contact the Department of Health Professionals toll-free complaint line: 1-800-533-1560.

Complaint forms, written procedures, and assistance are available to help you in filing a written complaint.

We will notify you of the outcome of your complaint within a reasonable time, but no later than 30 calendar days after we receive your complaint.

If your complaint is related to your request for an expedited appeal, we will respond **within 24 hours** after the receipt of the complaint.

Appeals Process:

You have the right to appeal any adverse benefit determination (decision) that you disagree with that relates to coverage or payment of services.

For example, you can appeal if Optima Health Community Care denies:

- A request for a healthcare service, supply, item, or drug that you think you should be able to get, or
- A request for payment of a healthcare service, supply, item, or drug that Optima Health Community Care denied.

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You can also appeal if Optima Health Community Care stops providing or paying for all or a part of a service or drug you receive through the program's benefits that you think you still need. You may have the right to continue benefits while your appeal is pending. Please refer to your Member Handbook or call Member Services at 1-888-512-3171 to determine if you are able to continue benefits.

If you are not satisfied with a decision, you have 60 calendar days from the decision to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. Eligibility issues should be appealed directly to DMAS. You can call Member Services at one of the numbers below if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you 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. 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.

Send your Appeal request in writing to:

Optima Health Community Care
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
Member Services: 757-552-8360 or 1-888-512-3171

If you send your standard appeal by phone, it must be followed up in writing. Expedited process appeals submitted by phone do not require you to submit a written request.

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Timeframes for Appeals

Standard Appeals

If we have all the information we need, we will tell you our decision within 30 days of when we receive your appeal request. We will tell you within two (2) calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent within **30 calendar days** from the date of the initial receipt of the appeal request and after all information has been received. If additional time is required to research the appeal, the Plan may extend this timeframe by up to an additional **14 calendar days**. For any appeal decisions not rendered within 30 days where the member has not requested an extension, the Plan will provide written notice to the member with the reason for the delay. The notification will address exactly what the Plan needs for review and when the timeframe ends.

Expedited Appeals

If we have all the information we need, expedited appeal decisions will be made **within 72 hours** receipt of your appeal. We will tell you **within two (2) calendar days** after receiving your appeal if we need more information. We will tell you our decision by phone and send a written notice not to exceed three (3) business days from the initial receipt of the appeal. This timeframe may be extended by up to an additional 14 calendar days if the member requests the extension or if the Plan provides evidence satisfactory to DMAS that a delay in rendering the decision is in the member's interest. The plan shall provide written notice to the member or member's designee of the reason for the delay for any extension not requested by the member.

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APPEAL REQUEST FORM

Today's Date: _____

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

Member Name:_____

Subscriber Name: _____

Address: _____

Home #:_____ Work#:_____

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

Please clearly describe the circumstances regarding the member's request for an appeal of a final adverse determination using additional paper, if needed:

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_____ _____

DATE **SIGNATURE**