
Please read the information below carefully. The form that you need to complete starts on page two.

If we deny a claim in whole or in part and you do not agree, you can ask for a review. This is called an appeal. There are **two ways** to do this:

1. Informal Review — *Optional*

You can call Customer Service at 800.235.7111 or 501.228.7111 to talk about your claim issue. Our hours are Monday — Friday, 8:00 a.m. to 5:00 p.m., Central Time. We may be able to solve your issue quickly outside the formal process. If Customer Service cannot solve the issue, he or she will tell you of your right to appeal.

2. Formal Appeals Process

- You can fill out and mail or fax this form to us (page 2 and 3 only) and any attachments. This form must be received by us in the time frames below.
- You may also send us a letter asking for an appeal. If you are sending a letter you must give us all the facts that are asked for on the form. Your letter must also tell us why you do not agree with our finding. This letter must be received by us in the time frames below.
- You may also orally give us your appeal if the denial was based on medical necessity. Call us at 501.228.7111 or 800.235.7111 and ask to speak to an Appeals Representative. This type of appeal must be made in the time frames below.

Time Frames

Level I Internal Appeal is to QualChoice. Refer to your plan documents for time frames.

Level II Internal Appeal is to CHI — your plan sponsor. Refer to your plan documents for time frames.

External Review — if your claim is still denied after your Level I and Level II internal appeals are done; you may be eligible for an external review by an independent third party. If eligible, you must ask for an external review in writing within four (4) months of getting a final denial letter. Please check with your group administrator or refer to your plan documents for details.

Authorized Representative

You may appeal on your own. You also may give someone else the authority to appeal for you. This is called an authorized representative. You must designate this person in Section IV.

Expedited Appeal

We make decisions for urgent care claims more quickly. If your doctor feels that a delay will put your health, your life, or your recovery at serious risk or cause you severe pain, that's an **urgent** care claim. You or your doctor may ask for an expedited appeal. Call us at 501.228.7111 or 800.235.7111 and ask to speak to an Appeals Representative.

Member Appeal Request Form

Please check one: This is my first appeal. This is my second appeal

Section I. Member Identification. Please print.			
Member Name (<i>Last, First, Middle Initial</i>)	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Phone	QualChoice ID No.	Today's Date (MM/DD/YYYY)
Street Address	City	State	Zip
Policyholder Name (<i>Last, First, MI</i>). <i>If SAME as member, mark SAME. If member is a minor, policyholder must also sign Section V.</i>			

Section II. Claim/Service Being Appealed
Have services already been received? <i>Check 'Yes' or 'No' and give explanation below.</i>
<input type="checkbox"/> Yes If YES, please provide: Provider's Full Name: _____ Date of Service on EOB: _____ EOB Claim No: _____ Billed Amount: _____ Send a copy of your <i>Explanation of Benefits (EOB)</i> with this form.
<input type="checkbox"/> No If NO, please provide: The planned date for the service (MM/DD/YYYY) _____. Please send a copy of your denial letter from QualChoice. <i>Tell us why you are appealing and why you do not agree with our decision. Please write clearly. Attach extra pages if needed. Each page must be signed, dated and include the member's name and QualChoice ID No.</i> _____ _____ _____ _____ _____

Section III. Appeal Information. From the EOB or denial letter, check the reason for the denial. Send the requested information with your appeal.	
Reason for Denial. <i>Please check one.</i>	What to send with your appeal
<input type="checkbox"/> Benefit is excluded or limited	<ul style="list-style-type: none"> ▪ Evidence of Coverage or Benefit Summary section that applies ▪ Reasons why you believe it applies to your appeal
<input type="checkbox"/> Not medically necessary	<ul style="list-style-type: none"> ▪ A letter from your doctor that supports medical necessity ▪ Copy of medical records that apply
<input type="checkbox"/> Procedure believed to be experimental or investigational	<ul style="list-style-type: none"> ▪ A letter from your doctor that supports medical necessity ▪ Copy of medical records that apply ▪ Peer-reviewed medical literature that applies
<input type="checkbox"/> Provider not in-network	<ul style="list-style-type: none"> ▪ A letter from in-network provider supporting need to use out-of-network provider ▪ Reason the provider believes this service could not be supplied in-network ▪ Copy of medical records that apply
<input type="checkbox"/> Claim not paid correctly	<ul style="list-style-type: none"> ▪ Tell us how <u>and</u> why you believe the claim should have been paid

Member Appeal Request Form

Section IV. Appointment of Representative

You must fill out this section if you are giving someone else the authority to act on your behalf in this appeal. You must also sign Section V even if you are using an authorized representative to act on your behalf.

I am giving the person named below the authority to act on my behalf in this appeal.

Print Name of Authorized Representative	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Phone	Relationship to Member
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■ **NOTE:** Members 18 and over must sign Section V. If the member is not able to sign, Section V must be signed by the person who is filling out and signing this form. The reason the member is not able to sign this form must be given. Also, proof of legal right (such as Healthcare Power of Attorney or Court Order) must be attached.

Section V. Authorization to Release Health Information. This authorization expires at the end of the appeal. The member can also cancel this authorization at any time by written request to QualChoice.

1. If this appeal is sent by someone other than me, I understand that I will be bound by the actions and decisions of that person. I acknowledge that the steps taken by that person are the appeal rights given to me under my health plan.
2. I approve the release of any medical or administrative records important to this appeal to an External Review Organization and, if applicable, to the person who sent in this appeal on my behalf.
3. I understand the following:
 - A copy of this form and any attachments may be sent to an independent External Review Organization.
 - This authorization does not change my enrollment, eligibility or payment of benefits.
 - The information I have agreed to be disclosed may be subject to re-disclosure and no longer protected by health privacy law.
 - I may review my appeal file by calling the QualChoice Appeals Representative.

Member Signature <i>(if a minor, the Policyholder must sign)</i>	Policyholder Signature <i>(only if member is a minor)</i>	Date Signed (MM/DD/YYYY)
X		

■ **If the member is not able to sign Section V, the person signing on their behalf must give the reason below.**

Please give the reason the member is not able to sign this form.

Section VI. Instructions. The address below is for appeals **only**. Any other requests sent to this address will delay our handling of your request. Please only send page 2 and 3. Be sure to keep a copy of your completed form.

Mail QualChoice ATTN: Appeals Representative P.O. Box 25610 Little Rock, AR 72221-5610	Fax QualChoice ATTN: Appeals Rep Fax: 501.228.9413
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Documents Attached. *Please check all items that are enclosed.*

- Copy of Explanation of Benefits (EOB) or your denial letter from QualChoice.
- Section of *Evidence of Coverage or Benefit Summary* that applies to your appeal
- Letter of Medical Necessity from your doctor
- Medical records from your doctor that support your appeal
- Supporting peer-reviewed medical literature from your doctor
- Operative Report (i.e., surgery notes) from your doctor
- Radiology/Lab Reports
- Proof of Legal Authority to sign Section V *(if applicable)*
- Other. *Please describe.*

Non-Discrimination and Accessibility Notice

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at (501) 228-7111. If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the QualChoice Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, sex, age or disability. QualChoice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for QualChoice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination. QualChoice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government. ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbāl in jipañ ilo kajin ñe am ejjelōk wōñāān. Kaalōk 1-800-235-7111 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711)。

Lao

ໂປດອຸາວ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-235-7111 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقم هاتف الصم والبكم: 117).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711) まで、お電話にてご連絡ください。

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).