QualChoice® HEALTH INSURANCE

Member Appeal Request Form

Please read the information below carefully, then complete the form starting on page 2.

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*

Call Customer Service at 800.235.7111 or 501.228.7111 to talk about your claim issue. We may be able to solve it quickly outside the formal process. If the Customer Service representative cannot solve the issue, he or she will tell you about your right to appeal.

2. Formal Appeals Process

Fill out and mail page 2 and 3 and/or 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 form or your letter must be received by us in the time frames below.

Plan Type	Level I: Internal Appeal	Level II: Internal Appeal	External Review
Group	Send your appeal form or letter within **180 days** of getting your *Explanation of Benefits (EOB)* or a denial (adverse determination) letter.	Send your appeal form or letter within **30 days** of getting our ruling on the first appeal.	You may ask for an External Review by a third party once the internal appeals process is done.
Individual & Family	Send your appeal form or letter within **180 days** of getting your *Explanation of Benefits (EOB)* or a denial (adverse determination) letter.	*No Level II Appeal*	You may ask for an External Review by a third party once the internal appeals process is done.
Self-Funded	Level I appeal is directed to QualChoice. Refer to your plan documents for time frames.	Level II appeal is directed to your plan sponsor. Refer to your plan documents for time frames.	

You may make the appeal on your own or name someone else to appeal for you. This is called an *authorized representative*. You must fill out and sign Section IV to name this person.

You may mail or fax the appeal form and any attachments to us. 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 Rep. Our hours are Monday-Friday, 8:00 a.m. to 5:00 p.m.

Expedited Appeal: 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. In this case, you or your doctor may ask for an *expedited* (faster) appeal. Call us at 501.228.7111 or 800.235.7111 and ask to speak to an Appeals Rep.

External Review: If your claim is still denied after your internal appeals are done, you may be able to ask for an *external review* by an outside third party.

- **Group or Individual Plans:** In some cases you can ask for an external review before the internal review is done. Go to www.insurance.arkansas.gov to learn more. Click *Consumer Services,* then *External Review.* Or call the Arkansas Insurance Department at 800.282.0134.
- **Self-Funded Plans:** 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.

QualChoice® HEALTH INSURANCE

Member Appeal Request Form

Please check one: ☐ This is my first appeal. ☐ This is my second appeal **(Group Plans Only)**

Section I. Member Identification

Print Member Name *(Last, First, Middle Initial)*	Phone: ☐ Home ☐ Work ☐ Cell	QualChoice ID No.	Today's Date (MM/DD/YYYY)

Street Address	City	State	Zip

Print Subscriber Name *(Last, First, MI) – if SAME as member, mark SAME. If member is a minor, subscriber must also sign Section V.*

Section II. Claim/Service Being Appealed

Have services already been received? *Please check Yes or No and explain below.*

☐ Yes **If YES:**

Provider's Full Name:_______________________________ Date of Service on EOB:____________________

Claim No. on EOB: _______________________________ Billed Amount:____________________

Send a copy of your *Explanation of Benefits (EOB)* with this form.

☐ No **If NO:**

What is the planned date for the service (MM/DD/YYYY)? ____________________ Please send a copy of denial letter.

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.

Section III. Appeal Information

Check the reason for the denial given on the *EOB* or denial letter. Send this information with your appeal.

Reason for Denial *Please check one.*	**What to send with your appeal**
☐ Benefit is excluded or limited	*Evidence of Coverage* or *Benefit Summary* section that applies Reasons why you believe it applies to your appeal
☐ Not medically necessary	A letter from your doctor that supports medical necessity Copy of medical records that apply
☐ Procedure believed to be experimental or investigational	A letter from your doctor that supports medical necessity Copy of medical records that apply Peer-reviewed medical literature that applies
☐ Provider not in the QualChoice Network	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
☐ Claim not paid correctly	Tell us how **and** why you believe the claim should have been paid

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 an authorized representative is acting 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	Phone ☐ Home ☐ Work ☐ Cell	Relationship to Member

■ **NOTE:** Members 18 and over must sign Section V themselves. 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 below. 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 understand 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 other records important to this appeal to an External Reviewer and, if needed, to the person who made 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 Reviewer.
   - 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 heaalth privacy law.
   - I may review my appeal file by calling the QualChoice Appeals Rep.

Member Signature *(if a minor, the Policyholder must sign)*	Policyholder Signature *(only if member is a minor)*	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. Send pages 2 and 3 only. Keep page 1 for your files.

Mail	**Fax**
QualChoice ATTN: Appeals Rep P.O. Box 25610 Little Rock, AR 72221-5610	QualChoice ATTN: Appeals Rep Fax: 501.228.9413

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*:

1010 CR 017_06 6.30.16

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 Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 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
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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: 711).

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).