Health Net Part C
How to Request an Appeal

If you disagree with the initial decision (denial letter), you or your appointed representative can ask for an appeal. An appeal is a formal way of asking us to review and change a medical coverage decision we have made. You or your appointed representative may also appeal our decision not to reimburse you for medical care services that you paid for.

- To start an appeal you, your representative, or in some cases your doctor must contact our plan.
- If you, your representative, or in some cases your doctor, are asking for a standard appeal, make your standard appeal in writing by submitting a signed request. Or, use the Health Net® Medicare Programs Appeals & Grievance form along with copies of any information that may be relevant to your appeal. You may send or fax your appeal to the following address:

Health Net® Medicare Programs
P.O. Box 10344
Van Nuys, CA 91410-0344
Phone: 1-800-275-4737
Fax: 1-877-713-6189
TTY/TDD: 1-800-929-9955
Hours of Operation:
8:00 a.m. to 8:00 p.m.
7 days a week

- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or Appeal on your behalf.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.

  - There may be someone who is already legally authorized to act as your representative under State law.

  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call the Customer Contact Center and ask for the Appointment of Representative (AOR) form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

- If your health requires it, ask for a "fast appeal" also known as an expedited request, (you can make an oral request) by calling us at 1-800-275-4737 between 8:00 a.m. to 8:00 p.m., 7 days a week. TTY/TDD: 1-800-929-9955.
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal
- You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.

    - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
    - If you wish, you and your doctor may give us additional information to support your appeal.

Appeal Request for a "fast" appeal (Expedited Appeal):

- When we are using the fast appeal, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.

    - However, if you ask for more time, or if we need to gather more information that may benefit you; we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
    - You may file an Expedited Grievance if you don't agree with the extension.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Appeal request for a Standard Service Appeal;

Upon receiving your written appeal request, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your

health condition requires us to.

  - However, if you ask for more time, or if we need to gather more information that may benefit you; **we can take up to 14 more calendar days.**
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization.
  - You may file and Expedited Grievance if you don't agree with the extension.

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- To make sure we were following all the rules when we said no to part or all of your appeal, our plan is required to automatically send your appeal to the "Independent Review Organization." Please refer to your Evidence of Coverage for more information on this process.

Appeal request for payment reimbursements

- If you make an appeal for reimbursement, we must give you our answer within **60 calendar days** after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

- To make sure we were following all the rules when we said no to your appeal, our plan is required to send your appeal to the "Independent Review Organization." When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2. We will send you a written notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal. Please refer to your Evidence of Coverage for more information on this process.

Health Net Part C
How to File a Grievance

Contact us promptly – either by phone or in writing.

Usually, calling the Customer Contact Center is the first step. You or your representative may contact us at the above phone number to make a complaint about your medical care. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or if your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Grievance procedure**.** If there is anything else you need to do, the Customer Contact Center will let

you know. **1-800-275-4737**. Calls to this number are free. Hours of Operation: 8:00 a.m. to 8:00 p.m., Pacific Time, seven days a week. TTY: **1-800-929-9955**.

- To file a grievance in writing, please print and complete the Health Net Medicare Programs> Appeals & Grievance form or write a letter stating the nature of the complaint, giving dates, times, persons, places, etc. involved. You may send or fax your grievance to the following address:

Health Net® Medicare Programs
P.O. Box 10344
Van Nuys, CA 91410-0344
Phone: 1-800-275-4737
Fax: 1-877-713-6189
TTY/TDD: 1-800-929-9955
Hours of Operation:
8:00 a.m. to 8:00 p.m.
7 days a week

You need to file your complaint within 60 calendar days after the event. We can give you more time if you have a good reason for missing the deadline. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

In certain cases, you have the right to ask for a fast review of your grievance. This is called the Expedited Grievance procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following circumstances:

- We deny your request for a fast review of a request for medical care
- We deny your request for a fast review of an appeal of denied services
- We decide additional time is needed to review your request for medical care
- We decide additional time is needed to review your appeal of denial medical care

You may submit this type of complaint telephonically to the Customer Contact Center number listed above. You may also submit this request in writing. Once the expedited grievance is received by us, a Clinical Practitioner will review the case to determine the circumstances surrounding the denial of your request for a fast review or if the case extension was appropriate. You will be notified of the outcome of the fast case orally and in writing within 24 hours of initial receipt of the case.
If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

- **Whether you call or write, you should contact the Customer Contact Center right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a**

expedited grievance. If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above. When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. In California and Arizona, the Quality Improvement Organization is called Health Services Advisory Group (HSAG) In Oregon it is called Acumenta Health .If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). If you make a complaint to this organization, we will work with them to resolve your complaint. You may contact the QIO for quality of care complaints at:

ARIZONA
Health Services Advisory Group (HSAG)
3133 East Camelback Road, Suite 300
Phoenix, AZ 85016
Phone #: 1-800-359-9909
Fax #: 602-264-4361
Website: www.hsag.com

CALIFORNIA
Health Services Advisory Group
700 N. Brand Blvd. Suite 410
Glendale, CA 91203
Phone Number :(818) 409-9229

OREGON
Acumentra Health
2020 SW 4th Avenue
Suite 520
Portland, OR 97201-4960
Phone Number: (503) 279-0100
Fax Number: (503) 279-0190

WASHINGTON
Qualis Health
10700 Meridan Avenue, North
Suite 100
Seattle, WA 98133-9075
Phone Number: (206) 364-9700
Fax Number: (206) 368-2419

For all other states, please refer to your Evidence of Coverage (EOC).

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Health Net Part C Member
Appeal & Grievance Form

Please note that completion of this form is not required to file an appeal or grievance. You may write a letter stating the nature of the complaint, giving dates, times, persons, places, etc. involved. Please include copies of any additional information that may be relevant to your complaint or appeal and send or fax to the following address:

Health Net® Medicare Programs
P.O. Box 10344
Van Nuys, CA 91410-0344
Phone: 1-800-275-4737
Fax: 1-877-713-6189
TTY/TDD: 1-800-929-9955
Hours of Operation:
8:00 a.m. to 8:00 p.m.
7 days a week

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of medical coverage or quality of care provided to you. Health Net **is required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call the Customer Contact Center. The customer service contact information may be found on your Health Net identification card.

Please print or type the following information:

_____
Member Name (Last, first, middle initial)

_____ _____
Address Home Phone number

_____ _____
City, State, Zip Work Phone number

_____ _____
Name of Employer or Group Enrollment ID #

_____ _____
Date of Birth Male/Female

Authorized Representative: If the complaint is filed by someone other than the member, please complete the Appointment of Representative (AOR) form or attach a copy of a Healthcare Durable Power of Attorney or other
legal document appointing you to act as the member's representative.

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

_____
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_____

Please sign and forward to Health Net at the address or fax number at the top of this form.

Date_____ Signature_____

Date_____ Signature of Representative_____
_____

A Medicare Advantage organization with a Medicare contract.