



INFORMATION ABOUT APPEALS, COVERAGE DETERMINATIONS AND GRIEVANCES

What kinds of problems are handled by the complaint process?

The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive.

A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care is called a **grievance**. This type of complaint does not involve coverage or payment disputes.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, 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.

Coverage Determination

A decision about whether a medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or prescription.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.
- But in some cases we might decide the service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Asking for an exception

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an “exception.” An exception is a type of **coverage decision**. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request.

A Medicare Advantage organization with a Medicare contract

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Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

Appeal

An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Who May File An Appeal, Grievance or Coverage Determination?

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others already may be authorized under State law to act for you.

If you would want someone to act for you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

Additional questions?

For more information on coverage determinations, exceptions, appeals, and grievances please see the Chapter titled “What to do if you have a problem or complaint (coverage decisions, appeals, complaints” in your 2010 Evidence of Coverage.

The contact information for requesting coverage determinations, as well information for filing either a grievance or appeal is listed at the end of this document.

Part C (Medical Benefits):

Coverage Determinations Phone: 1-800-748-2544
TTY: 1-800-743-3333
Fax: 1-317-573-2841
Mailing: ADVANTAGE Health Solutions
9045 River Road Suite 200
Indianapolis, IN 46240

Appeals and Grievances Phone: 1-866-591-6737
TTY: 1-800-743-3333
Fax: 1-888-771-4905
Mailing: ADVANTAGE Health Solutions
9045 River Road Suite 200
Indianapolis, IN 46240

Part D (Prescription Drug Coverage):

Coverage Determinations Phone: 1-877-684-0014
TTY: 1-866-763-9630
Fax: 1-866-250-5178
Mailing: EnvisionRxOptions
Attn: Coverage Determinations Dept.
2181 East Aurora Road
Twinsburg, OH 44087

Appeals Phone: 1-877-684-0014
TTY: 1-866-763-9630
Fax: 1-866-250-5178
Mailing: EnvisionRxOptions
Attn: Appeals Dept.
2181 East Aurora Road
Twinsburg, OH 44087

Grievances Phone: 1-866-591-6737
TTY: 1-800-743-3333
Fax: 1-888-771-4905
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