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 the date on the Level I appeal decision letter.	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.

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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 health 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 QualChoice ATTN: Appeals Rep P.O. Box 25610 Little Rock, AR 72221-5610	**Fax** QualChoice ATTN: Appeals Rep Fax: 833-744-1736

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*: