HOW TO FILE GRIEVANCES AND APPEALS

This material is being provided to you in accordance with Arizona's Health Care Appeals Law. If you have any questions about this Law or the appeals process, you may call Ambetter from Arizona Complete Health, Inc. at 1-888-926-5057 (TTY 711 for the hearing impaired) or you may call the Consumer Services Division of the Arizona Department of Insurance at 602-364-2499 or 1-800-325-2548 (outside the Metro Phoenix area).

YOUR SATISFACTION IS OUR CONCERN

At Ambetter from Arizona Complete Health, we want you to be pleased with the quality of care and service you receive. Surveys show that most of our members are satisfied and many stay with Ambetter from Arizona Complete Health year after year. We hope you are one of those members. If not, we want to hear from you so we can improve.

Anytime you have a concern about the quality of care you receive, the level of our service or any other aspect of your health plan – we want to know. Call us toll free at 1-800-289-2818 TTY 711 for the hearing impaired. Many times, a single phone call to our Customer Contact Center staff can make things right.

In addition to calling our Customer Contact Center, there are other avenues for you to use if you do not agree with a decision made by Ambetter from Arizona Complete Health or by one of the health care professionals who work with us. Like you, we want to be sure the appropriate decisions are made regarding your medical care and that you receive the benefits your health plan covers.

SHOULD YOU FILE A GRIEVANCE OR AN APPEAL?

Grievance

You initiate a grievance when you are not satisfied with the quality of care or service you are receiving.

Appeal

You file an appeal in response to a denial received from Ambetter from Arizona Complete Health. This could be a denial of coverage for requested medical care or for a claim you filed for care already received.

TO GET STARTED

Phone

You can initiate either the appeal or grievance process by phone. Just call our Customer Contact Center, Monday through Friday from 7 a.m. to 6 p.m. at 1-888-926-5057 (TTY 711 for the hearing impaired).

Mail

You can mail a written appeal or grievance to:

Appeals and Grievances Department
Attn: Appeals & Grievances Manager
Ambetter from Arizona Complete Health
P.O. Box 277610
Sacramento, CA 95827-7610

Fax

You may also fax a written appeal to the Ambetter from Arizona Complete Health Appeals and Grievances Department at 1-877-615-773.

THE GRIEVANCE PROCESS

A grievance is the first step you take to tell Ambetter from Arizona Complete Health that we are not meeting your expectations. A grievance tells us that you are not pleased with the quality of medical care or the service that you received. A grievance brings your concern to our attention.

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We want you to let us know how we can improve any aspect of your medical care, preventive health benefits, customer service or your understanding of your health plan. Call, write or fax your grievance to us. Ambetter from Arizona Complete Health will acknowledge receiving your grievance within five days. You will receive a decision within 30 days. Occasionally, Ambetter from Arizona Complete Health may take an extra 15 days to receive and review information before we send you our decision. Every grievance about the quality of medical care is taken seriously. That's why we have a Quality Improvement Department for investigation and follow-up with the doctor or facility that provided the care

THE APPEAL PROCESS

An appeal asks Ambetter from Arizona Complete Health to review its denial of your request for coverage of medical care or claim for reimbursement. Your appeal goes to people who have not reviewed your case before. In many cases, you can call, write or fax your request to start the appeal process.

You'll want to know that medical information is reviewed by physicians at every level – from your primary care physician, to a referral specialist, other doctors in the medical group and Ambetter from Arizona Complete Health's medical directors. The type of care requested must be medically necessary – and it must be a service or treatment that is covered by your health plan.

In many cases, you can present the specifics of your initial appeal by phone.

These are the levels of Ambetter from Arizona Complete Health's appeal process. Not every appeal is eligible for all levels of review:

- Formal Appeal
- External Independent Review
- Expedited Appeal
- Expedited External Independent Review

You are entitled to receive upon request, and free of charge, access to and copies of document and records, including the benefit provision, guideline, protocol and other criterion Ambetter from Arizona Complete Health used to make a denial determination. Make your request in writing and be sure to include the address where you want your records sent.

You have the right to representation at all levels of appeal by anyone you choose to act on your behalf. To exercise this right, an appointment of representative form should be provided to Ambetter from Arizona Complete Health along with your request for appeal. Nothing herein limits a member's right to pursue any appropriate legal action, nor shall it act as a waiver of any defense by Ambetter from Arizona Complete Health.

Formal Appeal

This is the first step in the process if you are an Individual and Family Plan member. You have up to two years after date of the denial to request a Formal Appeal. This is the second next step in the appeal process for a group member, following the Informal Reconsideration. For group members, the Formal Appeal must be requested within 60 days after receiving Ambetter from Arizona Complete Health's response to the Initial Determination. You must request a Formal Appeal in writing and send it to the Ambetter from Arizona Complete Health Appeals and Grievances Department. The Ambetter from Arizona Complete Health Appeals and Grievances Department will oversee the processing of your appeal. Include detailed information from you and your doctor to support your request for care or payment of a claim. Ambetter from Arizona Complete Health will send you and your doctor an acknowledgment, along with another copy of this How to File Grievances and Appeals information, within five business days after receiving your request. We will review the information provided, make a decision and notify you and your doctor, along with criteria used and any clinical reasons for the decision, within 30 calendar days for pre-service appeals and within 60 calendar days for claims or post service appeals. Ambetter from Arizona Complete Health may overturn its earlier denial and approve specified medical services or pay the claim. We also may uphold the original decision. In that case, you can take the final step in the appeals process – request an External Independent Review.

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However, if your appeal is related to the enforcement of or adjustments to a deductible, copayment or coinsurance requirement, the formal appeal is the last level of review. Under Arizona law, those appeals are not eligible for External Independent Review.

External Independent Review
After you have filed a Formal Appeal and if Ambetter from Arizona Complete Health has upheld its earlier denial, the next step is an External Independent Review. This is the final level of appeal for both group and Individual and Family Plan members and goes beyond Ambetter from Arizona Complete Health to include outside reviewers. You do not have any financial responsibility for the costs of this review. You must send your request in writing to the Ambetter from Arizona Complete Health Appeals and Grievances Department within 4 months after you receive Ambetter from Arizona Complete Health's decision. The Ambetter from Arizona Complete Health Appeals and Grievances Department will oversee the processing of your appeal. Within 5 days, Ambetter from Arizona Complete Health will send to you, your doctor and the Arizona Department of Insurance (ADOI) an acknowledgment that we have received your request. This level of appeal has two options based on the reason for the original denial:

Is The Care Medically Necessary?
If your issue is based upon a determination of whether the services are medically necessity, as defined in your policy, Ambetter from Arizona Complete Health will forward your case to the Arizona Department of Insurance within 5 business days. You do not have any financial responsibility for the costs of this review. The Arizona Department of Insurance will submit your request, with all supporting documentation, to the external medical reviewer within 5 business days. The external medical reviewer must notify the Arizona Department of Insurance of its decision within 21 days. After receiving the external medical reviewer's determination, the Arizona Department of Insurance will mail the decision to you, your Provider and Us within 5 business days.

Is the Care a Covered Benefit?
If your appeal is based upon a determination of whether certain services are covered under your policy, the Arizona Department of Insurance will make a determination as to whether the requested service or the claim is covered. Your request and your records will be forwarded to the Arizona Department of Insurance within 5 business days. You do not have any financial responsibility for the costs of this review. The Arizona Department of Insurance has to make a determination and mail the decision to you, your Provider, and Ambetter from Arizona Complete Health within 15 business days. If the Arizona Department of Insurance cannot make a determination on an issue of benefit Coverage, your request and the supporting documentation will be sent to an independent reviewer organization within 5 business days. The external medical reviewer must notify the Arizona Department of Insurance of its decision within 21 days. After receiving the external medical reviewer's determination, the Arizona Department of Insurance will mail the decision to you, your Provider and Ambetter from Arizona Complete Health within 5 business days.

The External Independent Review is the final step in Ambetter from Arizona Complete Health's appeal process. (You may qualify for an Expedited External Independent Review. The criteria for this level are outlined below.)

Expedited Appeal
An Expedited Appeal the first step in the process if you are an Individual and Family Plan member and is used when Ambetter from Arizona Complete Health has denied coverage for a medical service and the treating provider verifies that the time period for Formal Appeal process could cause a significant negative change in the insured's medical condition. You can initiate the Expedited Appeal by mailing, phoning or faxing your request to the Arizona Complete Health Appeals and Grievances Department. The Ambetter from Arizona Complete Health Appeals and Grievances Department will oversee the processing of your appeal. Once Ambetter from Arizona Complete Health receives the necessary information, we will respond within 72 hours. We may overturn the original decision and approve specified medical services. We also may uphold the original denial. In that case, Ambetter from Arizona Complete Health will provide telephonic and written notification of the adverse decision to you and your treating Provider. Upon notification that the original denial was upheld, you may ask for the next level of review – the Expedited External Independent Review.

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Expedited External Independent Review
After you have filed an Expedited Medical Review and if Ambetter from Arizona Complete Health has upheld its earlier denial, the next step is an Expedited External Independent Review. This is the final level of appeal and goes beyond Ambetter from Arizona Complete Health to include outside reviewers. You do not have any financial responsibility for the costs of this review. You must send your request in writing to the Ambetter from Arizona Complete Health Appeals and Grievances Department. Within 5 business days after you receive Ambetter from Arizona Complete Health's decision on your Expedited Medical Review. Within one business day Ambetter from Arizona Complete Health will send to you an acknowledgement that we have received your request and forward your case to the Arizona Department of Insurance. This level of appeal has two options based on the reason for the original denial.

Is the Care Medically Necessary?
If Ambetter from Arizona Complete Health denied your request for care or your claim because it was not medically necessary, then other medical professionals will review your case. *Within 2 business days,* The Arizona Department of Insurance (ADOI) will choose an Independent Review Organization (IRO) and send it the documentation for review. Ambetter from Arizona Complete Health will give the ADOI your medical records, a description of the criteria and clinical reasons used when making its decision, the name and credentials of the provider who reviewed the appeal and any other supporting information. Upon receipt of all required documentation, the IRO has 72 hours to issue a decision. Upon receipt of the decision, the ADOI has 1 business day to transmit the decision to the Health Plan, the Insurer, and the treating provider.

Is the Care a Covered Benefit?
If Ambetter from Arizona Complete Health determined the care you requested or your claim for services received was not covered by your health plan, your case will be sent to the Arizona Department of Insurance (ADOI). At this point in the appeal process, the ADOI can direct Ambetter from Arizona Complete Health to approve coverage for specified medical care or pay the claim or it can uphold Ambetter from Arizona Complete Health's original decision. Within 2 business days upon receipt of all required information, the ADOI will issue a decision and transmit it to the Ambetter from Health Plan, the Insured, and the treating provider.

The ADOI can also determine that the type of care requested is covered by your health plan and may elect to submit the case to an independent reviewer to decide if the care is medically necessary.

The Expedited External Independent Review is the final step in Ambetter from Arizona Complete Health's Expedited Appeal process. There is no further appeal for denied services or claims.

OTHER APPEAL & GRIEVANCE INFORMATION

Getting Your Medical Records
Under Arizona law, you and your health care decision-maker are entitled to a copy of your medical records from any health care professional that has treated you. Make your request in writing and be sure to include the address where you want your records sent. In some cases, your records will be sent only to the medical professional that you have designated.

Confidential Medical Information
Your medical records are confidential. They are used only as needed to make decisions about your care – or any appeals you may file. During an appeal, Ambetter from Arizona Complete Health may release some portions of your medical records to the people who are reviewing your case.

Mailing Documents
We want to be sure our response reaches you. Please confirm that Ambetter from Arizona Complete Health has your current mailing address in our records because that is where documents will be sent. We consider information mailed to you to be received on the fifth business day.

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The Role of the Director of the Arizona Department of Insurance
The Director of the ADOI will oversee this appeals process. The Director will maintain a copy of each health plan's utilization review policy; receive, process and act on requests from health plans for External Independent Review; review and enforce or overturn the decisions of the health plans; and file appropriate reports with the Arizona Legislature. When necessary, the Director must transmit appeal records to the Superior Court or the Office of Administrative Hearings and issue final administrative decisions.

Questions
If you have questions or need assistance, please call Ambetter from Arizona Complete Health's Customer Contact Center at 1-888-926-5057 (TTY 711 for the hearing impaired).

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the Employee Benefits Security Administration at 1-866-444-3272 or the Arizona Department of Insurance's Consumer Division at 602-364-2499 or 1-800-325-2548 (outside the Metro Phoenix area).

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name _____ Member ID # _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____ Phone # _____

City _____ State _____ Zip Code _____

Type of Denial: ☐ Denied Claim ☐ Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing?

_____

_____

_____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

_____

_____

_____

_____

_____

_____

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548, or Ambetter from Arizona Complete Health at (888)-926-5057 (TTY 711 for the hearing impaired). Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service including: □ Medical records □ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) **Also attach the certification from your treating provider if you are seeking expedited review.

_____ _____

Signature of insured or authorized representative Date

You can mail this form to: Ambetter from Arizona Complete Health Appeals and Grievances Department, Attn: Appeals & Grievances, P.O. Box 277610, Sacramento, CA 95827-7610.

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS
(You and your provider may use this form when requesting an expedited appeal)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 calendar days) "is likely to cause a significant negative change in the member's medical condition at issue."

PROVIDER INFORMATION
Treating Physician/Provider _____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

PATIENT INFORMATION
Patient's Name _____ Member ID # _____
Phone # _____
Address _____
City _____ State _____ Zip Code _____

INSURER INFORMATION
Insurer Name _____
Phone # _____ FAX# _____
Address _____
City _____ State _____ Zip Code _____

- Is the appeal for a service that the patient has already received? ☐Yes ☐No
  If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process
  If "No," continue with this form.

- What service denial is the patient appealing? _____

_____

_____

- Explain why you believe the patient needs the requested service and why the time for the standard appeal Process will harm the patient. _____

_____

_____

Attach additional sheets if needed, and include: ☐ Medical records ☐ Supporting documentation

If you have any questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548. You may also call Ambetter from Arizona Complete Health at (888)-926-5057 (TTY 711).

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the formal appeal processes (about 30 calendar days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature _____ Date _____

***** *Please fax signed, completed form and supporting medical records to:* *****
Ambetter from Arizona Complete Health Appeals and Grievance 877-615-7734

Discrimination is Against the Law

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

Ambetter from Arizona Complete Health:

- 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 and information written in other languages

If you need these services, contact Member Services at:
Ambetter from Arizona Complete Heatlh 1-888-926-5057 (TTY: 711)

If you believe that Arizona Complete Health 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 the Chief Compliance Officer, Cheyenne Ross. You can file a grievance in person, by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

Submit your grievance to:
Ambetter from Arizona Complete Health Chief Compliance Officer-Cheyenne Ross
1870 W. Rio Salado Parkway, Tempe, AZ 85281. Fax: 1-877-615-7734
Email: AzCHMarketplace@AZCompleteHealth.com

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 at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: 1-800-368-1019, 1-800-537-7697 (TTY).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

La discriminación es contra la ley

Ambetter from Arizona Complete Health cumple con las leyes Federales de derechos civiles correspondientes y no discrimina con base en la raza, el color, la nacionalidad, la edad, la discapacidad o el sexo. Arizona Complete Health no excluye a las personas ni las trata en forma distinta debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

Ambetter from Arizona Complete Health:

- Proporciona, sin cargo alguno, ayudas y servicios a las personas con discapacidades para que se comuniquen en forma eficaz con nosotros, como: intérpretes de lenguaje de señas calificados.
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Proporciona, sin cargo alguno, servicios de idiomas a las personas cuyo idioma primario no es el inglés, como: intérpretes calificados e información por escrito en otros idiomas.

Si necesita estos servicios, llame al Centro de Contacto con el Cliente de:
Ambetter from Arizona Complete Health al: 1-888-926-5057 (TTY: 711)

Si considera que Arizona Complete Health no ha proporcionado estos servicios o que ha discriminado de otra manera con base en la raza, el color, la nacionalidad, la edad, la discapacidad o el sexo, puede presentar una queja ante el Director General de Cumplimiento (Chief Compliance Officer), Cheyenne Ross. Puede presentar la queja en persona o por correo, fax, o correo electrónico. Su queja debe estar por escrito y debe presentarla en un plazo de 180 días a partir de la fecha en que la persona que presenta la queja se percate de lo que se cree que es discriminación.

Presente su queja a:
Ambetter from Arizona Complete Health, Chief Compliance Officer-Cheyenne Ross
1870 W. Rio Salado Parkway Tempe, AZ 85281. Fax: 1-877-615-7734
Correo electrónico: AzCHMarketplace@AZCompleteHealth.com

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de Estados Unidos, electrónicamente mediante el Portal de Quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal.lobby.jsf, o por correo postal a U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; o por teléfono: 1-800-368-1019, 1-800-537-7697 (TTY).

Los formularios para presentar quejas se encuentran en http://www. hhs.gov/ocr/office/file/index.html

Attention: If you speak a language other than English, oral interpretation and written translation are available to you free of charge to understand the information provided. Call 1-888-926-5057 (TTY: 711).

Spanish	Si habla español, dispone sin cargo alguno de interpretación oral y traducción escrita. Llame al 1-888-926-5057 (TTY: 711).
Navajo	Diné k'ehjí yáníłti'go ata' hane' ná hóló̜ dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchį́įgo nich'į' ádoolníiłgo bee haz'ą́ ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'į' ąą'át'é. Kojį' hólne' 1-888-926-5057 (TTY: 711).
Chinese (Mandarin)	若您讲中文，我们会免费为您提供口译和笔译服务。 请致电 1-888-926-5057 (TTY: 711)。
Chinese (Cantonese)	我們為中文使用者免費提供口譯和筆譯。請致電 1-888-926-5057 (TTY: 711)。
Vietnamese	Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ thông dịch bằng lời và biên dịch văn bản miễn phí dành cho quý vị. Hãy gọi 1-888-926-5057 (TTY: 711).
Arabic	إذا كنت تتحدث اللغة العربية، تتوفر لك ترجمة شفهية وترجمة تحريرية مجانًا. اتصل بالرقم 1-888-926-5057 (TTY: 711).
Tagalog	Kung ikaw ay nagsasalita ng Tagalog, mayroong libreng oral na interpretasyon at nakasulat na pagsasalin na maaari mong gamitin. Tumawag sa 1-888-926-5057 (TTY: 711).
Korean	한국어를 하실 경우, 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. 1-888-926-5057 (TTY: 711)번으로 전화하십시오.
French	Si vous parlez français, vous disposez gratuitement d'une interprétation orale et d'une traduction écrite. Appelez le 1-888-926-5057 (TTY : 711).
German	Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: 1-888-926-5057 (TTY: 711).
Russian	Если вы говорите по-русски, услуги устного и письменного перевода предоставляются вам бесплатно. Звоните по телефону 1-888-926-5057 (TTY: 711).
Japanese	日本語を話される方は、通訳（口頭）および翻訳（筆記） を無料でご利用いただけます。 電話番号 1-888-926-5057 (TTY: 711)。
Persian (Farsi)	اگر به زبان فارسی صحبت میکنید, ترجمه شفاهی و کتبی بدون هزینه برای شما قابل دسترسی میباشد. با شماره 1-888-926-5057 (TTY:711) تماس بگیرید.
Syriac	[illegible] 1-888-926-5057 (TTY: 711).
Serbo-Croatian	Ako govorite srpsko hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite 1-888-926-5057 (TTY: 711).
Thai	หากคุณพูดภาษา ไทย เรามีบริการล่ามและแปลเอกสาร โดยไม่มีค่าใช้จ่าย โทรศัพท์ 1-888-926-5057 (TTY: 711)