



Grievance and Appeals Process for Network Health Insurance Corporation

YOU HAVE A RIGHT TO APPEAL

You can appeal if you do not agree with Network Health Insurance Corporation's decisions about your health care. You must file your appeal in writing within 60 calendar days after the date of the denial. We can give you more time if you have a good reason for missing the deadline. **You have the right to appeal if you think:**

- Network Health Insurance Corporation will not approve or give you care it should cover.
- Network Health Insurance Corporation is stopping care you still need.
- Network Health Insurance Corporation has denied payment for services or items you have received and are not covered and you think it should be covered.

WHO MAY FILE AN APPEAL?

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 also already may be authorized under State law to act for you.

To learn how to name your authorized representative, you can call us at: (800) 378-5234 or TTY/ TDD (800) 947-3529 8 am to 5 pm Monday through Friday.

If you 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.

To file a grievance or appeal, you can call us at 800-378-5234 or send it to us in writing by faxing to 920-720-1909 or mailing to Network Health Insurance Corporation, P. O. Box 120, Menasha, WI 54952.

THERE ARE THREE KINDS OF APPEALS

Standard (30 days) if your request is for medical coverage/services- You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Standard (60 days) if your request is for payment of services you have received- You can ask for a standard appeal. We must give you a decision no later than 60 days after we get your appeal.

Fast (72 hour review)-You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- **If any doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal.**
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 30 day.
- We will make a decision on your appeal and notify you of it within 72-hours of receipt of your request. However, if our decision is not fully in your favor, we will automatically forward your appeal request to the CMS contractor (MAXIMUS Federal Services) for an independent review. MAXIMUS will send you a letter with their decision within three working days of receipt of your case from Network Health Insurance Corporation.

SUPPORT FOR YOUR APPEAL

You are not required to submit additional information to support your request for services or payment for services already received.

Network Health Insurance Corporation is responsible for gathering all necessary medical information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your Primary Care Physician. If your medical records from specialist physicians are not included in your medical record from your Primary Care Physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you.

YOU HAVE THE RIGHT TO PRESENT YOUR CASE IN PERSON

(The following information applies to both 30-day and 60 day appeals)

Network Health Insurance Corporation will provide an opportunity for you to provide additional information in person or in writing. You or your representative will be notified at least seven (7) business days in advance of the time and date that the Grievance and Appeals Committee will hear your case.

WHAT HAPPENS NEXT?

If you appeal, we will review our decision. After we review our decision, if payment for any of your claims is still denied, we will automatically forward your appeal request to the CMS Contractor (MAXIMUS Federal Services) for an independent review. This is provided by Medicare for a new and impartial review of your case outside of your Medicare Advantage Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.