#25 Appeal

Fully Insured Group – CHIP

If you do not agree with this decision, you may do one or all of the following:

- File a complaint/grievance with us.
- Ask for the medical necessity guidelines or other rules we used to make this decision.
- Get a second opinion from another doctor in our network.

File a Complaint/Grievance

You may file a complaint/grievance **within 60 days from the date you get this notice.**

Submit your complaint/grievance:

By Phone:	Call Keystone Health Plan East, Inc. at 1-800-464-5437 (TTY: 711)
By Fax:	Fax the “Complaint/Grievance Request Form” or a letter to 1-888-671-5274; or
By Mail:	Mail the “Complaint/Grievance Request Form” or a letter to the following address: Keystone Health Plan East, Inc. Member Appeals Department P.O. Box 41820 Philadelphia, PA 19101-1820

You may attend the review in-person, over the phone or by video conferencing. If you do not attend the review, it will not affect the decision.

You may have someone you know act on your behalf. This person will be “your representative." You must inform us in writing of the name of that individual and how to contact them.

You will receive a decision by no more than 30 calendar days from receipt of the complaint/grievance request.

Ask for an Early Decision

If your doctor or dentist believes that waiting 30 calendar days to get a decision could harm your health, you may ask that your complaint/grievance be decided more quickly.

> You must ask for an early decision by calling Keystone Health Plan East, Inc. at 1-800-464-5437 (TTY: 711) or faxing a letter to 1-888-671-5274.
>
> Your doctor or dentist should fax a signed letter to 1-888-671-5274 within 72 hours of your request for an early decision that explains why Keystone Health Plan East, Inc. taking 30 calendar days to tell you the decision about your complaint or grievance could harm your health.

We will tell you the decision about your complaint/grievance within 48 hours from when we get your doctor's or dentist's letter, **or** within 72 hours from when we get your request for an early decision, whichever is sooner, unless you ask us to take more time to decide your complaint/grievance. You can ask us to take up to 14 more days to decide your complaint/grievance.

Information Used to Make this Decision

You or your representative may ask us to see any information used to make the decision about your service or item, at no cost to you.

To ask for the information:

- Call us at 1-800-464-5437 (TTY: 711) or
- Check *yes* on number 2 of the "Complaint/Grievance Request Form" or send a letter.

The Form or the letter can be sent to:

Fax number: 1-888-671-5274

Mailing address:

Keystone Health Plan East, Inc.
Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820

Get Guidelines and Rules

You may get a copy of the medical necessity guidelines or other rules Keystone Health Plan East, Inc. used to make the decision, at no cost to you. To ask for a copy of the medical necessity guidelines or other rules that we used to make the decision:

- Call us at 1-800-464-5437 (TTY: 711) or
- Send a letter to the following:

Fax number: 1-888-671-5274

Mailing address:

Keystone Health Plan East, Inc.
Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820

Get a Second Opinion

You may get a second opinion from a provider in Keystone Health Plan East, Inc.'s network. Asking for a second opinion will not give you more time to file a Complaint/ Grievance. It will not continue any service or item that you have been receiving.

To ask for a second opinion, call Keystone Health Plan East, Inc. at 1-800-464-5437 (TTY: 711) to get a referral for a second opinion.

Help with Your Complaint/Grievance

If you need help filing a complaint/grievance, you can call Keystone Health Plan East, Inc. at 1-800-464-5437 (TTY: 711).

To ask for free legal help with your complaint/grievance, you can contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net).

COMPLAINT/GRIEVANCE REQUEST FORM

Enrollee: _____ **Enrollee UCI:**_____

Parent/Guardian: _____**Phone number:** _____

Address: _____

Date on the Notice of Decision: _____

1. **Check how you would like to do the review of your complaint/grievance:**
   ☐ **BY TELEPHONE** (You will be sent the date and time of the review. You will be called at the phone number you provided above.)
   ☐ **BY VIDEOCONFERENCE [MCO to include only if available]** (You will be sent the date, time, and location of the review.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the review.)
   ☐ **NOT BE PRESENT** (You can change your mind at any time. You will be sent the date and time of the review. The decision on your complaint/grievance will not be affected if you are not present.)

2. **Would you like a copy of the information Keystone Health Plan East, Inc. used to make the decision about your service or item? Yes ☐ No ☐**

3. **Do you need an interpreter or language services? Yes ☐ No ☐ Language?**_____
   (Interpreter and language services will be provided free of charge)

4. **Why do you disagree with Keystone Health Plan East, Inc.'s decision?** (Attach more pages if needed. You will be able to explain why you disagree during the review.)
   _____
   _____
   _____
   _____

5. **If someone will be helping you with your complaint/grievance, please provide their information:** (If you do not yet have anyone helping you, just leave this blank and you can let Keystone Health Plan East, Inc. know later if someone will be helping you.)
   Representative's name and phone number: _____
   Representative's address: _____
   Relation to enrollee: _____

Enrollee's Signature: _____Date:_____

Send to: Keystone Health Plan East, Inc., Member Appeals Department, P.O. Box 41820, Philadelphia, PA 19101-1820
fax #1-888-671-5274