

How to File a Complaint or Appeal with your Health Plan

General Information:

- When you have a disagreement with your health plan over whether services are covered, what treatments should be followed or which providers you can use you always have the right to file a complaint.
- Every health plan must have a process for handling members' complaints. Each health plan must resolve complaints within a specific amount of time. This information must be in your member handbook. Non-emergency complaints must be resolved within 30 days.
- Your health plan cannot retaliate against you (by canceling your coverage) because you filed a complaint.
- If you believe your health plan denied your medically necessary care, you can appeal the decision. The plan should send you a letter telling you why they denied the service and how to file an appeal.

Filing a Complaint:

- Contact your health plan's customer service line. They will take down your complaint and must send you a response within five days to let you know they received it. Some plans may require you to submit your complaint in writing.
- Within 30 days the plan will send you a written response (notification letter) with their decision and a proposed resolution of your complaint.
- If you do not agree with the health plan's decision, you may request an appeal.
- All Medicaid recipients have the right to appeal any decision concerning a denial, delay, termination, suspension, or reduction of their Medicaid covered services.

Appealing the Plan's Decision

- When you file an appeal with your health plan you will be required to submit the details in writing. Usually health plans have a form you can fill out. Member services can help you put your complaint or appeal in writing.
- The health plan must send you a letter within five days of your request letting you know that they received your request.
- Within 30 days the plan will send you a written notice of their Final Decision from the appeal process. In some situations you will get a response a lot sooner.
- If you need the health plan to make a quick decision based on your health status (taking the time for a standard appeal could jeopardize your life or health) you may request an expedited appeal. The health plan is required to make a final decision, and notify you within 3 days. You may ask the state for an expedited Medicaid Fair Hearing when the issue is the denial of authorization for a service.
- Some health plans have more than one level in their appeals process. If you are not satisfied with the decision, ask your health plan if you can appeal the decision any further.
- The notice of Final Decision will also contain information on how you can request a Medicaid Fair Hearing.

- You have the right to ask for a Medicaid Fair Hearing at the same time that you are getting an appeal through your health plan.