Important facts about Your appeal rights

PO Box 91110
Sioux Falls, SD 57109
(855) 305-5060 | TTY/TDD: (877) 652-1844
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sanfordhealthplan.com

SANFORD HEALTH PLAN

What if I need help understanding a denial and my rights?

For help with this notice or our decision not to pay for an item or service, call us toll-free at (855) 305-5060 TTY/TDD (877) 652-1844. We are open from 8 a.m. to 5 p.m. CT, Monday to Friday. If you need free help in a language other than English, call toll-free (800) 892-0675.

What if I don't agree with a decision?

You have the right to appeal any part of a decision not to provide or pay for an item or service. If you disagree with a decision, **you have 60 calendar days from the date we send a denial** to tell us you want to appeal. If you would like to keep getting the services or benefits we denied while you appeal, you must tell us you want to appeal within **10 calendar days** of getting this notice.

How do I file an appeal?

You or your provider can appeal by calling or writing us. If you decide to appeal by calling, we will use the date you call as the filing date for your appeal. If you appeal in writing, send us a letter or use the Appeal Filing Form. We will let you know when we receive your appeal, usually by mailing you a letter.

Who may file an appeal?

You, or someone you tell us in writing is allowed to speak for you, like a doctor or family member, may file an appeal. This person is known as your authorized representative. If the person who was denied a benefit or service has died, their estate's legal representative may file an appeal. **If you want someone else, like your provider, to appeal for you, you must give written permission and we must be given a copy.**

Can I give more facts about my appeal?

Yes, you can give us more details, including records or notes you would like considered in your appeal. You can give these facts in person, by calling us, or sending copies of items you want included. Keep copies of all paperwork you send us.

Can I get copies of papers related to my appeal?

Yes, you can get free copies. If you think a coding error may have caused a claim to be denied, you have the right to get billing codes sent to you for free. To get copies, call us or send us a secure message through your mySanfordHealthPlan Member Portal at sanfordhealthplan.com/memberlogin.

What if I need a fast decision?

If you or your provider think your need is urgent, tell us when you file your appeal. Generally, an urgent situation is when your health may be in serious danger or, if your doctor believes your pain cannot be well controlled while you wait for a decision on your appeal. If we deny your request for an urgent review, we will call you and also mail you a letter explaining this decision within 24 hours. Your appeal will then follow the standard appeal decision timeframe. If you disagree with our denial of your request for an urgent review, you may file a complaint with us.

What happens next?

For standard appeals, we will make a decision within 30 calendar days from the day we receive your appeal. We will make a decision on an urgent appeal within 72 hours. If you are still unhappy with our decision, you may have the right to request a State Fair Hearing. You may be required to pay the cost of health care services provided during your appeal if the final decision says your benefits will be denied. If you receive a Non-Covered Service Determination, you have no right to a State Fair Hearing.

What if I need help filling out paperwork?

We will help you fill out appeal paperwork and can assist you in other ways to understand the appeal filing process. We can read forms to you over the phone. North Dakota Medical Services can also help and you can call them at (844) 854-4825 | ND Relay TTY: (800) 366-6888 (toll-free).

Appeal Filing Form

Member name:_____
First *Middle* *Last*

Member ID# From Your ID Card: _____Date of Birth: _____

Name of person filing appeal: _____

Check one: ☐ Self (Patient) ☐ Authorized Representative (Family/Caregiver) ☐ Provider/Doctor

Contact information for person filling out this form

Address: _____

Email: _____ Daytime Phone: _____

If the person filling out this form is other than the patient/member, then the patient must give permission for the appeal by signing here:

_____
Patient Signature

Do you need an urgent (expedited) appeal? ☐ Yes ☐ No

Do you want the services being appealed to continue while you appeal? *(if applicable)*
☐ Yes ☐ No

Tell us why you don't agree with this decision *(you may attach medical records, or other facts, to support your case)*:

_____

_____

_____

Tell us which request decision you disagree with:

Date(s) of Service: _____ Referral #(s): _____

What provider(s) did you see? _____

What services or procedures did you get? _____

Send this form and your denial notice to us at:

Sanford Health Plan/NDME Appeals
P.O. Box 91110
Sioux Falls, SD 57109-1110
FAX: (605) 328-6813 (long-distance charges may apply)

Keep copies of this notice and all documents and correspondence related to this request.