Sanford Heart of America Health Plan

Member Complaint Procedure & Appeals Process

If you are dissatisfied about something that Sanford Heart of America Health Plan has done or not done, you have the right to file a complaint or appeal. You can tell us why you are dissatisfied and we will review the situation and resolve it. This document explains the process and how to file the complaint or appeal.

For step-by-step instructions, please refer to your Evidence of Coverage chapter titled "What to do if you have a problem or complaint" (coverage decision, appeals, and complaints).

How to Make a Complaint or File a Grievance

The complaint process is used for certain types of problems: quality of care, waiting times, physician behavior, customer service, involuntary disenrollment, or other concerns related to your Sanford Heart of America Health Plan. Please refer to your Evidence of Coverage chapter titled "What to do if you have a problem or complaint (coverage decision, appeals, and complaints)".

After you have identified a problem, you have 60 days to file a complaint or grievance. Begin by contacting our Customer Service Team.

Contact us by:

Phone	Fax	Mail
Toll free: (877) 652-1845 TTY/TDD (877) 652-1844 Monday-Friday 8 a.m.– 8 p.m. CT	(605) 328-6813	Sanford Heart of America Health Plan PO Box 1999 Fargo, ND 58107

After your complaint or grievance has been reviewed, we will contact you. In some cases, we may be able to answer your concern right away; however, most complaints or grievances are answered within 30 days. If we need more information, we may take an additional 14 calendar days (44 calendar days total) to respond to your complaint or grievance. If we do not agree with your complaint, we will give you a detailed explanation in our response.

You have the Right to an Expedited (Fast) Grievance:

- If you need a fast decision on a service supported by your doctor.
- If you need a fast appeal, please submit it with a supporting statement from your doctor.
- An additional 14 days may be needed in order to respond to your inquiry.

If your complaint or grievance is about the quality of care you received, you can make your complaint to us or you may make your complaint directly to:

Quality Improvement Organization

Call	Fax	Write
Toll free: (701) 852-4231	(701) 838-6009	North Dakota Health Care Review 800 31st Ave SW Minot, ND 58701

How to Ask for a Coverage Decision

A coverage decision is any decision we make about your benefits and coverage, or about the amount we will pay for your medical services.

Requesting Authorization Prior to Service

If you want to know if we will cover a medical service before you receive it; you, your doctor, or your representative may ask us to make a coverage decision for you. You may call, fax, or write a request for us to review your coverage for the medical care you want. When we give you our decision, we will use the "standard" decision time frame unless we have agreed to use the "fast" decision time frame. A standard decision time frame means we will give you an answer within 14 days after we receive your request.

If your health requires it, ask us to give you a fast decision, and we will answer within 72 hours. Requirements must be met to qualify for a fast decision. For example, you may get a fast decision only if you are asking for coverage for medical care not yet received.

A request for an "exception" is also a type of coverage decision. When you ask for an exception, your doctor will need to explain the medical reasons why you need the exception approved. We will then consider your request.

Making an Appeal about a Coverage Decision

If you are not satisfied with our coverage decision you may "appeal" the decision. An appeal is a formal way of asking us to review the coverage decision. When we have completed the review, we will give you our decision.

To start an appeal; you, your doctor, or your representative must contact us. You must make your appeal request within 60 calendar days from the date on the written notice we sent to you. If you miss this deadline for good reason, we may give you more time to make your appeal. If your health requires a quick response, you must call and ask for a "Fast" appeal. When we are using the Fast appeal time frame, we will give you our answer within 72 hours after we receive your appeal. When we are using the "Standard" appeal time frame, we will give you our answer within 30 days after we receive your appeal. If our answer is yes to part or all of what you requested, we will authorize the coverage we have agreed to provide within 30 days. If we need more information, we may take an additional 14 calendar days (44 calendar days total) to answer your appeal.

If your appeal for medical coverage is denied, we will send your appeal to the "Independent Review Organization" (IRO). The IRO is an independent organization chosen by Medicare to investigate all information related to your appeal. You will be informed of their decision in detail by letter. Should your appeal be denied and your case meets the requirements, you may choose whether or not to take the appeal further. There are three additional levels in the appeals process. Please refer to your Evidence of Coverage in the chapter "What to do if you have a problem or complaint (coverage decisions, appeals, complaints) for the step-by-step instructions".