## Important Information about Initial Decisions, Appeals and Grievances

You, your physician, treating provider, or authorized representative may request an organization determination, file an appeal or file a grievance with Medical Associates Health Plans (MAHP). If you want to authorize someone, call Member Services Department and ask for the "Appointment of Representative" form. The form is on our website at www.mahealthplans.com or on Medicare's Web site at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. This form must be signed by you and by the person who you would like to act on your behalf and MAHP must have a copy of the signed authorization form.

1. **Organization Determination (Initial Decision)** – when MAHP makes a decision about your benefits and coverage or about the amount MAHP will pay for your medical services. This would include a request for referral services.

   Standard pre-service request for items or services will be reviewed and responded to no later than 14 days from the date the request was received. A 14-day extension may be taken if you request the extension, if more information is needed and the delay is in your best interest, or if there are extraordinary circumstances (such as a natural disaster). Standard pre-service request for Part B drugs will be reviewed and responded to no later than 72 hours from the date the request was received.

   Expedited pre-service request for items or services will be reviewed and responded to no later than 72 hours from the date the request was received. A 14-day extension may be taken if you request the extension, if more information is needed and the delay is in your best interest, or if there are extraordinary circumstances (such as a natural disaster). Expedited pre-service request for Part B drugs will be reviewed and responded to no later than 24 hours from the date the request was received.

   Payment requests will be reviewed and processed within 30 days for contracted network providers and within 60 days for non-contracted providers from the date the request was received.

2. **Appeal (Reconsideration)** – when you ask for MAHP to review and change an initial decision we have made. You can ask for a reconsideration if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

   Standard and expedited appeals must be filed within 60 days from the date of the notice of the initial determination.

   Standard pre-service and benefit appeals will be reviewed and responded to no later than 30 days from the date the appeal was received. Standard Part B drug appeals will be reviewed and responded to no later than 7 days from the date the appeal was received. Expedited pre-service or benefit appeals will be reviewed and responded to as expeditiously as your health condition requires but no later than 72 hours. A 14-day extension may be taken if you request the extension,

if more information is needed and the delay is in your best interest, or if there are extraordinary circumstances (such as a natural disaster). No extension for Part B drug or payment appeals.

Additionally, you have the right to request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) of a decision that inpatient hospital care is no longer necessary or when a Skilled Nursing Facility (SNF), Home Health Agency (HHA) and comprehensive Outpatient Rehabilitation Services (CORF) decides to terminate previously approved coverage.

3. **Grievance (Complaint)** – a complaint you make about MAHP or one of our network providers including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

   Grievances must be submitted within 60 days of the event or incident. Decisions will be made as quickly as the case requires based on your health status, but no later than 30 days from the date the grievance was received for a standard grievance or within 24 hours for an expedited grievance. A 14-day extension may be taken if you request the extension or if more information is needed and the delay is in your best interest.

   For complete details of the appeals and grievance procedures, please refer to Chapter 7, titled "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)," in your Evidence of Coverage or contact the Member Services Department.

**Contact Information:**

Member Services Department
563-584-4885 or 1-866-821-1365, 8:00 a.m. to 8:00 p.m. CST, 7 days a week
TTY:1-800-735-2942
Fax: 563-584-4760
Email: memberservices@mahealthcare.com

MAHP is a Cost Plan with a Medicare Contract. Enrollment in MAHP depends on contract renewal.

You may also contact Medicare directly through their website, **www.medicare.gov**, or at 1-800-MEDICARE, 24 hours a day, 7 days a week.