



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

Appeal Process for Basic Health Members

As a Community Health Plan member, you have the right to file a complaint, an appeal related to a complaint resolution, or an appeal about a denied claim. To file a complaint about services from Community Health Plan or a request for the health plan to review its decision related to a complaint resolution, a denial of a claim or benefits interpretation (appeal), contact our customer service team at 1-800-440-1561. If you are hearing impaired, please call TTY 1-866-816-2479 (toll free) or local 206-613-8875. If you disagree with the outcome, you may appeal the decision.

You can submit a complaint, an appeal about a complaint resolution or appeal about a denied service in writing, in person at our office, or over the phone by calling our customer service team at the number listed above.

Send written appeals or complaints to:
Community Health Plan
Attn: Appeals Department
720 Olive Way, Suite 300
Seattle, WA 98101

Your request must include your name, address, Basic Health subscriber I.D. number and the reason for your appeal, along with any supporting documents. You can send anything that you feel will help your case. If you need help with your appeal, contact our customer service team at the number listed above.

There are time limits for filing an appeal:

1. You must file the appeal within 180 days from the date of a denial or complaint resolution you are not satisfied with made by Community Health Plan.
2. If Community Health Plan sends you a letter that tells you services will end, be stopped or be reduced and you want the services to continue while your appeal is being resolved, you may ask us to continue to pay for your services until whichever of the following takes place first:
 - You use up the number of visits or days on the original amount of services.
 - The appeal is decided.

NOTE: If the appeal decision related to continued services is not in your favor, you will have to pay for the cost of the services you received.

FIRST LEVEL APPEAL

We will acknowledge your appeal within 5 days of receipt. We will review your appeal. All the information you sent us is considered during the decision-making process. We will respond to you in writing within 14 days of receiving your appeal. The response you receive may be a decision or a notice of a delay in the appeal decision. If there is a delay, the response will include a reason for the delay and a date when you can expect a decision. We will resolve your appeal within 30 days of the request, unless we obtain your written consent for additional time.

EXPEDITED (RUSH) APPEAL

If you or your doctor feels that if you do not get care right away it could result in an emergency or jeopardize your life or health or your ability to attain, maintain, or regain maximum functioning, you can ask for an expedited (rush) appeal. Your doctor may speak with the Community Health Plan Medical Director or any other person working on your case. The rush appeal will take place within the quickest time frame possible but not more than 72 hours from the time we receive the request for it. You can give more information at any time during the 72 hours by calling our customer service team at the number listed above or by writing to us. The expedited appeal right and related time frames apply to all levels of the appeal process.

SECOND LEVEL APPEAL

If you do not agree with our decision, you may request a Second Level Appeal Committee review. You must request the Second Level review within 180 days from the date of the initial appeal decision. To request a Second Level Appeal Committee review, write to the Appeals Department at the above address or call our customer service team at the number listed above.

We will acknowledge your second level appeal request within 5 days of the receipt date and arrange for a Second Level Committee review within 14 days from the date we receive your request. We may request an extension to review the appeal, but will respond to you no later than 30 days of receipt of the second level appeal request.

Your second level appeal request acknowledgement includes an invitation for you and/or your authorized representative to attend the Second Level Committee meeting. If you wish to attend in person or by phone, notify the Appeals Department as soon as possible after receiving your acknowledgement letter. The Appeals Coordinator will then call you and tell you the date and time of the review.

We will inform you of the committee's decision in writing within 5 days after the committee meets, but no later than 30 days from the date we received your second level appeal request.

If you do not agree with the decision of the Second Level Appeal Committee or we have not responded to your appeal within 30 days, and your appeal involves a decision by us to deny, modify, reduce, or terminate coverage of payment for a health care service, you may request that an Independent Review Organization (IRO) review your appeal. The IRO which reviews your case will have no connection to Community Health Plan.

INDEPENDENT REVIEW

You may request a review of your appeal by an IRO, at no cost to you, by writing to the Appeals Department at the above address or by calling our customer service team at 1-800-440-1561. If you are hearing impaired, please call TTY 1-866-816-2479 or local 206-613-8875.

You must request an IRO review within 180 days of the denial by the Second Level Appeal Committee. We will give the IRO all of the information which was used in making the decision within three business days of receiving the request. You may be required to provide additional information or documentation needed for the IRO's decision. The IRO will notify you and Community Health Plan of their decision and their reasons for reaching that decision.

If waiting for a decision could put your health at risk, you can ask for an expedited review. In such a case, the IRO will make a decision within 72 hours.

EXPEDITED REVIEW BY AN IRO

You or your authorized representative may request an expedited review by an IRO. If Community Health Plan's Medical Director or your provider determines that the standard IRO timelines could seriously jeopardize your life or health or your ability to attain, maintain, or regain maximum functioning, the IRO must expedite its review process and issue a decision no later than 3 days after the receipt of the request for an expedited review by the IRO.

APPOINTING AN AUTHORIZED REPRESENTATIVE

At any time during the appeal or IRO process, you may choose someone, including an attorney or provider, to serve as your authorized representative to act on your behalf. We must receive written consent from you allowing this person to represent you before the person can act on your behalf. If you have questions related to appointing a personal representative, please contact the Community Health Plan customer service team at the number listed above.

In all levels of the appeal and IRO processes, all decisions related to your appeal are made by persons not involved in the initial determination. All decision makers have the appropriate credentials for the level of the decision involved.

You may ask at any time during the appeal process to look at your file and medical records and we will send a copy to you. You may also ask for a copy of the benefit provision, guideline, protocol, or other information about how the appeal decision was made.

If you have any questions about this procedure, contact the Community Health Plan customer service team at 1-800-440-1561. If you are hearing impaired, please call TTY 1-866-816-2479 (toll-free) or local 206-613-8875.