Coordinated Care Corporation

Grievance Process

A grievance is a complaint expressing dissatisfaction about our customer service or the quality or availability of a health service. For example, you may file a grievance if you have a problem with:

- the way you were treated,
- the quality of care or services you receive, or
- making an appointment.

Grievances must be filed with the Grievance Department within 180 days from the date the problem or issue occurred.

FILING A GRIEVANCE

You or your authorized representative can file a grievance with Ambetter from Coordinated Care. The Grievance Form and Authorized Representative Form are available under Member Resources on our website.

If you need help filing a grievance, please call 1-877-687-1197 (TTY:711). You can file a grievance by mail, phone, or fax at:

Ambetter from Coordinated Care
Grievance Department
P. O. Box 10341
Van Nuys, CA 91410
Email: Ambetter_centralized_grievances_appeals@centene.com

Phone: 1-877-687-1197
TTY: 711
Fax: 1-833-886-7956

AFTER YOU FILE A GRIEVANCE

- We will let you know we received your grievance within 5 business days of receipt.
- We will resolve and send you written resolution of your grievance within 30 days of receipt.
- We will keep your grievance private. Filing a grievance will not result in any discrimination against you.

Coordinated Care Corporation

Appeal Process

You or someone you choose can ask us to reconsider our decision regarding your benefits, prior authorization request or claim payment by filing an appeal with Ambetter from Coordinated Care. You must submit your appeal within 180 days of the date you received notice of the adverse decision (also known as an "adverse benefit determination").

If you want someone else to represent you in the appeal process, you must sign and submit an Authorized Representative form, available under Member Resources on our website. If a prior authorization request was denied, your provider may appeal the denial on your behalf without your written consent.

You can file an appeal by mail, phone, or fax at:

Ambetter from Coordinated Care
Appeals Department
1145 Broadway, Suite 700
Tacoma, WA 98402

Phone: 1-877-687-1197
TTY: 711
Fax: 1-855-218-0589

YOUR APPEAL SHOULD INCLUDE

- Your name
- Your member ID number
- A phone number where we can reach you
- Why you think we should change the decision
- Any information that supports your request

You or your provider may submit evidence for us to review during the appeal process. You may also request copies of the records, evidence, and criterion we used to make this decision, at no cost to you. If you have questions or need help filing your appeal, please call Member Services at 1-877-687-1197.

AFTER YOU FILE AN APPEAL

- We will send you a letter acknowledging we received your appeal within 72 hours of receiving it.
- For a non-expedited appeal, we will send you written notice of our decision within 14 calendar days.
- For appeals involving an experimental or investigational treatment, we will send you written notice of our decision with 20 calendar days.

EXPEDITED REVIEW

You or your provider may request expedited review if:

- you are currently receiving or are prescribed treatment or benefits that would end because of this decision; or
- your provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health, or ability to regain maximum function, or would cause you severe and intolerable pain; or
- this decision is related to admission, availability of care, continued stay, or emergency health care services, and you have not been discharged from the emergency room or transport service.

Expedited review of an appeal and expedited external review may be requested verbally or in writing. We will make a decision preferably within 24 hours but in no case longer than 72 hours of receiving the request.

External Review by Independent Review Organization

If your appeal of this decision is unsuccessful, you may request external review of our decision by an Independent Review Organization (IRO). External review by an IRO must be requested within 180 days of the date you receive the appeal decision.

You can request external review by mail, phone or fax by contacting the Appeal Department as listed above.

You are not responsible for the costs of the IRO's review. Requesting external review by an IRO will not result in discrimination against you. The IRO is unbiased, and not connected with Ambetter from Coordinated Care.

AFTER YOU REQUEST EXTERNAL REVIEW

- We will notify you of the name and contact information of the IRO reviewing your case within 1 day of selecting the IRO.
- You will have at least 5 business or for expedited IRO request within 24 hours days to submit additional information to the IRO.
- We will send your request and relevant information to the IRO for review within 3 business days of receiving the request.
- We will submit to the IRO: your medical records, any documentation used in making our decision, a list of health care providers who may have pertinent information regarding the issue, and any other information that you or your provider submitted to us.
- For non-urgent cases, the IRO must provide its determination within 15 calendar days after it receives the necessary information, or within 20 calendar days of receiving your request, whichever is sooner.
- For urgent/expedited cases, the IRO must provide its determination within 72 hours after it receives the necessary information.

Expedited external review may be requested at the same time as an expedited appeal in certain situations. If you have questions or need help requesting external review by an IRO, please call Member Services at 1-877-687-1197.

Continuation of Services

If you appeal or request external review of a decision that affects services or supplies you are currently receiving, we will continue to provide coverage for the disputed benefit during the appeal review period. To continue coverage for services affected by this decision, you must contact us and request continuation of coverage. If your appeal is unsuccessful, you may be responsible for the cost of coverage received during the review period. An IRO's decision at the external review level is binding unless other remedies are available under state or federal law.

If you have questions or concerns about the actions of your insurance company or agent, or would like information on your rights to file an appeal, contact the Washington state Office of the Insurance Commissioner's consumer protection hotline at 1-800-562-6900 or visit www.insurance.wa.gov. The insurance commissioner protects and educates insurance consumers, advances the public interest, and provides fair and efficient regulation of the insurance industry.