APPEALS/RECONSIDERATIONS (MEDICAL) AND GRIEVANCES GUIDE

The **Provider Portal** is the fastest way to submit Appeals and check status.
You can also check status of Appeals by calling Provider Services.

Appeals and Reconsiderations (Medical)

Appeals (Non-Participating Providers and Members)

Procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits.

Reconsiderations (Participating Providers)

A reconsideration is the first appeals process level. Reconsiderations involved plan reviewing an adverse organization determination, the findings they based them on, along with other evidence.

All non-participating provider appeals must be submitted within **180 calendar days from the date of the notice of the initial determination** and they must also submit a signed AOR with their request for processing. When submitting an appeal, the specific service being appealed must be listed on the appeal form. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

Participating providers must seek a reconsideration through the Appeals Department within **180 calendar days** (required timing is listed in your contract) of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. When submitting a reconsideration, the specific service being reconsidered must be listed on the appeal form. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

Appointment of Representative (AOR)

With the Member's written consent, an appeal for denial of an authorization for medical service can be filed on the Member's behalf by a participating Physician who has or is currently treating the Member. If the Member wishes to use a representative, they must complete an AOR form, ***or an equivalent written notice***. The Member and representative must sign the AOR form.

The appeal will not be considered valid until the AOR documentation is provided. AOR Forms can be found on the plan website, under Forms.

Mail, email or fax all medical appeals and reconsiderations with supporting documentation to:

Grievance
and Appeals Coordinator
Sunshine Health
PO Box 459087
Fort Lauderdale, FL 33345-9087

Email: **Sunshine_appeals@centene.com**
Fax: **1-866-534-5972**

Grievances

Member grievances may be filed verbally by contacting Customer Service or submitted in writing via mail, email or fax. Providers may also file a grievance on behalf of the member with the member's written consent, AOR forms are available on the plan website, under **Forms**.

Mail, email or fax all member grievances to:

Grievance
and Appeals Coordinator
Sunshine Health
PO Box 459087
Fort Lauderdale, FL 33345-9087

Email: **Sunshine_appeals@centene.com**
Fax: **1-866-534-5972**

NOTE: Ambetter Health does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

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