Member Appeal Rights
(Marketplace)

You received a Notice of Adverse Determination. This means that Community has:

- denied or reduced the authorization of a service.

Standard Appeal Process

You have the right to appeal an Adverse Determination. Your Provider or someone else that you choose as your representative may also appeal. You have 30 days from the date of the adverse determination to file your appeal. You may request your appeal verbally or in writing. Please send your appeal to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 or 1.888.760.2600

Fax to: 713.295.7033/Attn: Appeals Coordinator

During the Appeal Process

We will let you know we received your appeal within 5 business days. Community may need additional information to help us with your appeal. The letter will include a list of documents that you, your representative or Provider should send to Community for the appeal. You have the right to give us information which supports your appeal. You may review any information we use to make our decision.

Community will have someone review the appeal to make sure we have all the required information. Community will also have a doctor review your appeal. This doctor will be trained in treating your type of illness. This will be a doctor who was not part of the original decision.

Answering your Standard Appeal

- Community will answer your appeal within 30 calendar days after the date received.
- Reasons for the resolution
- Clinical basis for the decision
- Types of doctors that reviewed the appeal
- Your right to a review by Texas Department of Insurance Independent Review Organization (IRO) and how to request an IRO
-

Your provider has the right to ask for a specialty review within 10 days of our decision.

Expedited Appeal Process

You have the right to ask for an expedited appeal. This type of appeal is about emergencies, continued hospitalizations and life-threatening conditions. You can request an expedited appeal, either orally or in writing. Community will resolve your expedited appeal no later than 1 working day from the date all of the necessary information to complete the appeal is received. Community may provide the appeal determination by telephone or electronic transmission but you will receive a letter within three working days of the initial notification.

Retrospective Adverse Determinations

Adverse determinations related to retrospective reviews will be made within a reasonable period but not to exceed 30 days after the claim is received. The determination will be sent to the Provider, enrollee or a person acting on behalf of the enrollee in writing.

Appeal Denial - Review by an IRO

You have the right to an IRO review if you disagree with our appeal decision. If you are denied treatment because the treatment is considered to be experimental, investigational, medically unnecessary, or inappropriate. Community will send you information on how to request an IRO and the Request Form, with your appeal response letter.

You can bypass the internal appeal process if you or your doctor believes your condition is life-threatening. You may also bypass the appeal process if you are denied a claim for prescription drugs or intravenous infusions that you are currently receiving benefits for at the time of your appeal request.

You are not eligible for an IRO review; if we deny payment for a service not covered such as cosmetic surgery; or you have already received treatment and we determined that the treatment was not medically necessary.

Complaint Process

If you wish to file a complaint about the due process regarding appeals, you may do so verbally or in writing. If you file a verbal complaint you must also send a completed “Complaint Form”. We will send you a letter within five (5) business days letting you know that we have received your complaint. Once we receive your complaint, we will investigate it and respond with a Resolution letter within 30 calendar days. Please send your complaint to:

Community Health Choice, Inc.
Attention: Complaints Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 or 1.888.760.2600

You may also file a complaint with the Texas Department of Insurance:

Texas Department of Insurance
Consumer Protection Section (MC 111-1A)
P.O. Box 149091
Austin, TX 78714-9091
1.800.252.3439

Derechos de Apelación del Miembro
(Marketplace)

Usted recibió un aviso de determinación adversa. Esto quiere decir que Community Health Choice ha:

- negado o reducido la autorización de un servicio.

Proceso Estándar de Apelación

Usted tiene derecho a apelar una determinación adversa. Su Proveedor u otra persona que elija como representante también pueden apelar. Tiene 30 días a partir de la fecha de la determinación adversa para presentar la apelación. Puede solicitar su apelación verbalmente o por escrito. Envíe su apelación a la siguiente dirección:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Ste. 900
Houston, Texas 77054
713.295.2294 o gratis al 1.888.760.2600

Por fax: 713.295.7033/Attn: Appeals Coordinator

Durante el proceso de Apelación

Le informaremos sobre la recepción de su apelación dentro de 5 días hábiles. Es posible que necesitemos información adicional para contribuir al proceso de apelación. La carta incluirá una lista de documentos que usted, su representante o Proveedor deben enviar a Community Health Choice para la apelación. Usted tiene el derecho de proporcionarnos información que respalde su apelación. Puede revisar cualquier información que utilicemos para tomar nuestra decisión.

Community solicitará que alguien revise la apelación para garantizar que tenemos toda la información necesaria. Además, un médico revisará su apelación. El médico está capacitado en el tratamiento de su tipo de enfermedad. El médico no participó en la decisión original.

Respuesta a su Apelación Estándar

- Responderemos a su apelación dentro de 30 días calendario, a contar de la fecha de recibo.
- Razones de la resolución.
- Fundamentos clínicos para la decisión.
- Tipos de médicos que revisan la apelación.
- Su derecho a una revisión de una Organización de Evaluación Independiente (IRO, por sus siglas en inglés) del Departamento de Seguros de Texas y cómo solicitarla.
-

Su proveedor tiene el derecho de pedir una revisión de un especialista dentro de los 10 días de la decisión.

Proceso de Apelación Acelerada

Tiene derecho a solicitar una apelación acelerada. Este tipo de apelación está relacionada con emergencias, hospitalizaciones continuas y enfermedades potencialmente mortales. Puede solicitar una apelación acelerada, ya sea verbalmente o por escrito. Community Health Choice responderá a su solicitud acelerada en un plazo no superior a 1 día hábil a partir de la fecha de recepción de toda la información necesaria para completar el proceso. Podemos proporcionar la determinación de la apelación por teléfono o transmisión electrónica, pero recibirá una carta del aviso inicial dentro de tres días hábiles.

Denegación de la apelación - revisión por un IRO

Usted tiene el derecho a una revisión IRO si está en desacuerdo con nuestra decisión de apelación. Si se le niega el tratamiento porque el tratamiento es considerado como experimental, de investigación, médicamente innecesario o inapropiado. Community le enviará información sobre cómo solicitar una IRO y el formulario de solicitud del IRO, con su carta de respuesta a la apelación.

Usted puede omitir el proceso de apelación interna si usted o su médico creen que su condición pone en riesgo su vida. Usted también puede omitir el proceso de apelación si se le niega un reclamo para medicamentos con receta o infusiones intravenosas que usted está recibiendo actualmente como un beneficio en el momento que usted hace su solicitud de apelación.

Usted no es elegible para una revisión IRO; si el pago ha sido negado por un servicio que no está cubierto, como la cirugía estética; o porque nosotros hemos determinado que el tratamiento no era necesario médicamente.

Determinaciones Adversas Anteriores

Las determinaciones adversas relacionadas con revisiones anteriores se realizarán dentro de un período razonable no mayor a 30 días, a partir de la fecha de recepción de la reclamación. La determinación se enviará por escrito al Proveedor, al Miembro o a la persona que actúa en nombre del Miembro.

Proceso de Quejas

Si desea presentar una queja sobre el proceso de la apelación, puede hacerlo verbalmente o por escrito. Si usted presenta una queja verbal también debe llenar y enviar un "Formulario de Quejas " .Nosotros le enviaremos una carta dentro de cinco (5) días hábiles para hacerle saber que nosotros hemos recibido su queja. Una vez que recibamos su queja, nosotros investigaremos y responderemos con una carta de Resolución dentro de 30 días calendarios. Por favor enviar su queja a:

Community Health Choice, Inc.
Attention: Complaints Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 o gratis al 1.888.760.2600

Además, le recomendamos que presente una queja con el Departamento de Seguros de Texas a la siguiente dirección:

Texas Department of Insurance
Consumer Protection Section (MC 111-1A)
P.O. Box 149091
Austin, TX 78714-9091
1.800.252.03439

MEMBER APPEAL FORM
(Marketplace)

Member Name: _____

Address: _____

City, State & Zip: _____

Phone Number: _____

Member Number: _____

Is this a:

_____ Standard Appeal _____Expedited Appeal _____IRO Review-Standard

_____ IRO Review for urgent or life-threatening conditions

Briefly describe your appeal:

_____

_____

_____

_____

_____ _____

Signature Date

Please send your form to the following:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 or 1.888.760.2600

Fax to: 713.295.7033/Attn: Appeals Coordinator

You are not required to return the completed form but we encourage you to do so as it will help us to resolve your appeal.

FORMULARIO DE APELACIÓN PARA EL MIEMBRO
(Marketplace)

Nombre del Miembro: _____

Dirección: _____

Ciudad, estado y código postal: _____

Número de teléfono: _____

Número de Miembro: _____

Esta es una:

_____ Apelación estándar _____ Apelación acelerada _____ Revisión estándar de una IRO

_____ Revisión de una IRO para enfermedades urgentes o potencialmente mortales

Describa brevemente su apelación:

_____

_____

_____

_____

_____ _____

Firma Fecha

Envíe el formulario a la siguiente dirección:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 o gratis al 1.888.760.2600

Por fax: 713.295.7033/Attn: Appeals Coordinator

No está obligado a devolverlo lleno, pero lo instamos a que lo haga porque de esta forma nos ayudará a resolver su apelación.

TEXAS DEPARTMENT OF INSURANCE
Financial Regulation Division - Managed Care Quality Assurance (103-6A)
333 Guadalupe, Austin, Texas 78701 ★ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6400 | F: (512) 490-1013 | (866) 554-4926 | TDI.texas.gov | @TexasTDI

DO NOT RETURN THIS FORM TO TDI

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

INSTRUCTIONS

Instructions to Patient, Person Acting on Behalf or Representative of Patient/Employee, and Provider:
This form is being provided to you because your request for health care services has been denied as not medically necessary. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier. This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

To request an independent review of your case, you must take the following action:

- Complete the Request for a Review by an Independent Review Organization form (TDI Form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- Return the completed form to the company that sent you the denial letter as soon as possible. The company's address and/or fax number are either listed on page four of this form or on the denial letters. **DO NOT SEND THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE (TDI).** (For Workers' Compensation cases, you must return this form – requesting an IRO – within 45 calendar days).

The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned. The timeframes for an IRO's decision are as follows:

Coverage Types	Health	Workers' Compensation Network (WCN)	Workers' Compensation Non-Network (WC)
Life Threatening	3 days	8 days	8 days
Denial of Prescription Drugs or Intravenous Infusions - Concurrent	3 days	NA	NA
Non-Life Threatening Preauthorization/Concurrent	20 days	20 days	20 days
Retrospective	20 days	30 days from receipt of IRO fee*	30 days from receipt of IRO fee**

*Carrier pays the fee.
**Requestor pays the fee. (However, if the requestor is an injured employee, carrier pays the fee.)

Instructions to URA/Carrier:

APPLIES TO HEALTH CASES ONLY: The entity that is submitting this request to TDI must indicate in the documentation that this is a denial of prescription drugs or intravenous infusions for which the enrollee is already receiving benefits.

There is no cost to you for the independent review. **Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent review will be required to pay the IRO fee prior to the IRO beginning its review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.**

For information about the independent review process, please call TDI at 1-866-554-4926, Option 7.

REQUEST FORM

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's Date: Month_____ Day_____ Year_____

Name of Party Requesting IRO: _____ **Print Last Name, First Name and Middle Initial**	**Relationship to the Patient or Injured Employee:** **(Check one)** ☐ Self ☐ Person acting on behalf of patient or injured employee ☐ Provider acting on behalf of patient or injured employee ☐ Provider that received the denial ☐ Sub claimant (Workers' Compensation only)

REASON FOR REQUEST FOR REVIEW BY AN IRO

Is the condition life-threatening? Check one: ☐ Yes ☐ No (This question does not apply if services have been received)	Is this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits? Check one: ☐ Yes ☐ No (This question does not apply to workers' compensation cases)
Is the review ordered by a Court? ☐ Yes ☐ No	

DENIED SERVICES

Describe the health care services that are being denied (include dates only if services have been performed):

_____

PATIENT/INJURED EMPLOYEE INFORMATION

Health Plan or Claim Identification Number:_____

(This number is usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of Birth:*(month)* _____ *(day)* _____ *(year)*_____ Sex_____

Social Security Number _____-_____-_____

First Name_____Middle Name _____ Last Name _____Suffix_____

Street _____

City_____ State_____ Zip code_____

Phone: _____-_____ Fax: _____-_____

THIS FORM MUST BE RETURNED TO THE COMPANY THAT ISSUED THE DENIAL.
DO NOT RETURN THIS FORM TO TDI.

PROVIDER THAT RECEIVED THE DENIAL

Name_____

Federal Tax Identification Number _____

Street_____

City_____ State_____ Zip code_____

Phone: _____-_____ Fax: _____-_____

PROVIDER ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF *(IF APPLICABLE)*

Name_____

Federal Tax Identification Number _____

Street_____

City_____ State_____ Zip _____

Phone number: _____-_____Fax number: _____-_____

PERSON ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF *(IF APPLICABLE)*

First Name_____Middle Name _____Last Name _____Suffix_____

Relation to patient _____

Street_____

City_____State_____Zip _____

Phone number: _____-_____Fax number: _____-_____

THIS FORM MUST BE RETURNED TO THE COMPANY THAT ISSUED THE DENIAL.
DO NOT RETURN THIS FORM TO TDI.

RELEASE (The release must be signed by the patient, or his or her legal guardian.)
(NOT REQUIRED FOR WORKERS' COMPENSATION CASES)

I,_____ **(Print last name, first name and middle initial)**, the patient, parent, or patient's legal guardian ***(circle one)***, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed_____ Date: *(mo)* _____ *(day)* _____*(yr.)* _____

Note: For chemical dependency or mental health treatment, list the providers to which this release applies:

_____

_____

_____

_____

_____

RETURN THIS FORM **TO CARRIER/PAYOR OR UTILIZATION REVIEW AGENT**

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Toll-Free Number: _____ Fax Number: _____

Notice About Certain Information, Laws and Practices
With few exceptions, you are entitled to be informed about the information the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy.

Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please visit the Corrections Procedure section of TDI's website.

FOR INFORMATION ABOUT THE INDEPENDENT REVIEW PROCESS, PLEASE CALL TDI AT 1-866-554-4926, OPTION 7.

THIS FORM MUST BE RETURNED TO THE COMPANY THAT ISSUED THE DENIAL.
DO NOT RETURN THIS FORM TO TDI.

Provider Appeal Rights to an Adverse Determination (Marketplace)

As a Provider of Community Health Choice, Inc. (Community), you have the right to appeal a Notice of Adverse Determination. An Adverse Determination means that health care services provided or proposed to be provided are not medically necessary, not appropriate or experimental or investigational. This includes services provided and retrospective appeals. The following information will explain how to appeal an Adverse Determination.

Please note that an appeal to an Adverse Determination does not involve administrative denials, such as incorrect information on a claim (e.g., tax identification number), timely filing or adjustments to paid claims.

Standard Appeal Process

You have the right to appeal an Adverse Determination. You have 30 days from the date of the adverse determination to file your appeal. You may request your appeal verbally or in writing:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 or 1.888.760.2600

Fax to: 713.295.7033/Attn: Appeals Coordinator

An enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care Provider may appeal the adverse determination, orally or in writing for services provided, services not received or services currently being received that is deemed medically unnecessary by HMO. This includes retrospective appeals. The appeal acknowledgement letters will contain:

- The date of Community's receipt of appeal.
- A list of documents the appealing party must submit to Community for appeal.
- If the appeal is oral, Community will send a one-page appeal form.
- A written acknowledgement sent within five working days after receipt of appeal request.

Appeal decisions will be made by a physician (or dentist, if applicable) who was not involved in the previous determination. An appeal resolution letter will be sent to the patient/enrollee or a person acting on the patient/enrollee's behalf and the patient/enrollee's physician or other health care Provider and will contain:

a. Dental, medical, contractual reasons for resolution.
b. Clinical basis for decision.
c. Specialization of Providers consulted.
d. Notice of the appealing party's right to seek review by a like specialist.
e. Notice of the appealing party's right to seek review by a Texas Department of Insurance (TDI) approved Independent Review Organization (IRO) and procedures for obtaining that review.

If an appeal is denied, only the Provider may request, in writing, good cause for having a particular type of specialty Provider review the case, a health care Provider who is of the same or similar specialty as the health care Provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the decision denying the appeal. The request must be received within 10 business days. The specialty review must be completed within 15 working days of the date the health care Provider's request for specialty review is received. An acknowledgement letter will be sent within five (5) working days of receiving request for specialty review. The Provider may request a review by an Independent Review Organization.

The exhaustion of internal appeals is not necessary if: (a) the internal appeal process timelines are not met; or (b) in an urgent care or life threatening situation, the Member files for an external review before exhausting the internal appeal process.

An appeal resolution letter will be sent to the patient/enrollee or a person acting on the patient/enrollee's behalf and the patient/enrollee's physician or other health care Provider and will contain:

a. Dental, medical, contractual reasons for resolution.
b. Clinical basis for decision.
c. Specialization of Providers consulted.
d. Notice of the appealing party's right to seek review of the denial by an independent review organization and procedures for obtaining that review.

Denials of care for life-threatening conditions, emergencies, and continued hospital stays may be appealed as an expedited appeal.

You have 30 days from when you receive this notice to appeal. You may request your appeal verbally or in writing.

During the Appeal Process

Community will send an acknowledgment letter concerning your appeal within 5 business days. You have the right to give us information which supports your appeal. You may review any information we use to make our decision.

Because your appeal involves a question of medical necessity, Community will have a physician review the appeal. This physician will be someone who was not part of the original decision.

Answering your Appeal

Community will respond to your appeal within 30 days.

Expedited Appeal Process

You have the right to ask for an expedited appeal for a denial of emergency care, continued hospitalization and life threatening conditions. This type of appeal is when you feel your patient's condition could get worse if you wait for the standard appeal process. You can request an expedited appeal, either orally or in writing. Because your appeal involves a question of medical necessity, Community will have a health care Provider review the appeal. This health care Provider will be someone who has not previously reviewed the case and is of the same or a similar specialty as the health care Provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal. Community will respond to your expedited appeal based upon the medical or dental immediacy of the condition, procedure, or treatment under review, but the resolution of the appeal will not exceed one (1) working day from the date all information necessary to complete the appeal is received by Community.

Please send your expedited appeal to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 or 1.888.760.2600

Fax to: 713.295.7033/Attn: Appeals Coordinator

Appeal Denial - Review by an IRO

You have the right to an IRO review if you disagree with our appeal decision. If you are denied treatment because the treatment is considered to be experimental, investigational, medically unnecessary, or inappropriate. Community will send you information on how to request an IRO and the Request Form, with your appeal response letter.

You can bypass the internal appeal process if you or your doctor believes your condition is life-threatening. You may also bypass the appeal process if you are denied a claim for prescription drugs or intravenous infusions that you are currently receiving benefits for at the time of your appeal request.

You are not eligible for an IRO review; if we deny payment for a service not covered such as cosmetic surgery; or you have already received treatment and we determined that the treatment was not medically necessary.

Retrospective Adverse Determinations

Adverse determinations related to retrospective reviews will be made within a reasonable period but not to exceed 30 days after the claim is received. The determination will be sent to the Provider, enrollee or a person acting on behalf of the enrollee in writing.

Complaint Process

If you wish to file a complaint about due process regarding appeals, you may do so verbally or in writing. If you file a verbal complaint you must also send a completed "Complaint Form". We will send you a letter within five (5) business days letting you know that we have received your complaint. Once we receive your complaint, we will investigate it and respond with a Resolution letter within 30 calendar days. If your complaint is about a medical emergency or denial of a continued hospital stay, we will respond no later than one (1) business day. Please send your complaint to:

Community Health Choice, Inc.
Attention: Complaints Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 or 1.888.760.2600

You may also complain to the Texas Department of Insurance:

Texas Department of Insurance
Consumer Protection Section (MC 111-1A)
P.O. Box 149091
Austin, TX 78714-9091
1.800.252.3439

Provider Appeal Form
(Marketplace)

Name: _____

Address: _____

City, State & Zip: _____

Phone Number: _____

Member Number: _____

Is this a:

_____ Standard Appeal _____Expedited Appeal _____Standard IRO

_____ Request for review by an IRO for urgent or life-threatening conditions

Briefly describe your appeal:

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

Please send your form to the following:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 700
Houston, Texas 77054
713.295.2294 or 1.888.760.2600

Fax to: 713.295.7033/Attn: Appeals Coordinator
You are not required to return the completed form but we encourage you to do so as it will help us to resolve your appeal