



**Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, Virginia 23466-2876**

Dear Member:

Thank you for your request for information regarding the Plan's Complaint process. Please refer to your member materials for a detailed description of the Plan's complaint and appeals process. Enclosed you will find the following information to help guide you should you choose to file a complaint:

- Complaint Form;
- Designation Authorization Form (To appoint someone such as a physician or family member to act on your behalf in filing a complaint or appeal);
- Release of Information (This form is used so that the Plan can assist you in obtaining pertinent medical information from practitioners or providers in which health care services have been delivered).

In order for the Plan to address your concerns, your complaint must be submitted within 180 days from the date of your concern with care, service and/or policies and procedures of the Plan. Please send the completed Complaint Form and any additional information related to your concerns to:

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876
OR
Facsimile: (757) 687-6232
Toll-free facsimile: (866) 472-3920

You will be notified in writing within 5 business days that your information was received and the time required to research your concerns. Procedures for handling complaints and the associated time frames for resolving complaints will vary by the type of complaint received.

Your continued satisfaction with the Plan is our primary concern. If you have any questions regarding your complaint, please call the Appeals Department at (757) 687-6230.



A member has the right to designate an authorized representative, such as a provider or family member, to act on his or her behalf in filing an appeal of an Adverse Benefit Determination. This authorization may be granted for a particular event or date of service after which time the authorization is revoked, or may be granted for any present or future claim for health care benefits. Explanation of Benefit statements will not be directed to an authorized representative, but will continue to be sent to the Member. To designate an authorized representative, please complete this form and return to Optima Health Appeals Department.

**Optima Health Designation Authorization Form
Appeals Department**

Member Name: _____

Member ID#: _____ Date of Birth: _____

Health Plan: Optima Health Plan (OHP) Optima Health Insurance Co. (OHIC)

I hereby designate: _____
Name Relationship

Address

City, State, Zip

to act on my behalf in pursuing a claim for benefits or an appeal of an adverse benefit determination.

- This consent is valid for _____ days (Consent is valid for 180 days unless noted otherwise).
- Consent is valid until revoked by me.

I, the undersigned, understand that I may revoke this consent at any time. Also, upon fulfillment of the above stated purpose, I understand that my authorized representative or I may receive a copy of the release. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for a period of 180 days, unless otherwise noted above.

(State date, event, or condition of expiration)

Signed _____ Date _____

AUTHORIZATION TO RELEASE & OBTAIN PROTECTED HEALTH INFORMATION (PHI)

PLEASE PRINT

FIRST

MIDDLE

LAST

Member's Name: _____

Month Date Full 4-Digit Year

Member ID #: _____ Date of Birth: _____

I authorize **OPTIMA HEALTH** or _____ to exchange information with:

Individual: _____

Agency: _____

Address: _____

Phone Number: _____

Family _____ Relationship _____

Employer EAP

Aftercare Physician

Therapist Referral Source

For The Purpose of: *Diagnosis, Treatment & Discharge Planning, Continuity of Care* OR _____ (Be Specific)

This authorization covers the following Protected Health Information (PHI)

To Be RELEASED	To Be OBTAINED
Dates of Service _____ to _____ <small>(INSERT DATES OF SERVICE FOR INFORMATION TO BE RELEASED)</small>	Dates of Service _____ to _____ <small>(INSERT DATES OF SERVICE FOR INFORMATION TO BE RELEASED)</small>
<input type="checkbox"/> Claims Information	<input type="checkbox"/> List Information Being Requested:
<input type="checkbox"/> Clinical Notes	<input type="checkbox"/>
<input type="checkbox"/> Demographics & Benefits	<input type="checkbox"/>
<input type="checkbox"/> Other:	

NOTICE TO PARTY RECEIVING DRUG/ALCOHOL ABUSE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PROHIBITION ON REDISCLOSURE: The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse member. This information is confidential and protected by Federal Law. Any further redisclosure is strictly prohibited unless patient provides specific written consent for the subsequent disclosure of this information. This authorization is subject to patient revocation at any time except to the extent that action has already been taken.

If not previously revoked, this consent will expire (check one): 30 days Other: _____
(Specify Date or Event)

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I also understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by written notification. I understand that my revocation or modification of this authorization will not affect any actions taken by the entity in reliance on this authorization before it receives my request for revocation or modification. I must sign my written request and include it with my complaint or appeal documentation.

Patient / Representative Signature	Patient / Representative PRINTED Name	Date (Month/Day/Year)
IF NOT SIGNED BY PATIENT, AUTHORITY TO SIGN ON BEHALF OF PATIENT:		
Witness Signature	Witness PRINTED Name	Date (Month/Day/Year)

INCLUDE THIS COMPLETED FORM WITH YOUR COMPLAINT OR APPEAL DOCUMENTATION

Optima Health Alternative Language Options for Notices and other Written Information

English: This Notice has Important Information. This notice has important information about your application or coverage through Optima Health. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-687-6260.

Amharic:

ይህ ማስታወቂያ ጠቃሚ መረጃ አለው። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም በOptima Health በኩል ስለሚኖርዎት ሽፋን ጠቃሚ መረጃ አለው። በዚህ ማስታወቂያ ላይ ያሉትን ቁልፍ የሆኑ ቀናቶችን ያስተውሉ። የጤና ሽፋንዎን ለማስቀጠል ወይም ወጪዎችን ለማገዝ እንዲቻል በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ሊያስፈልግዎ ይችላል። በራስዎ ቋንቋ ያለምንም ክፍያ ይህን መረጃም ሆነ ድጋፍ የማግኘት መብት አለዎት። 1-855-687-6260 ይደውሉ።

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. يحتوي هذا الإخطار على معلومات مهمة تتعلق بطلبك أو ببرنامج التغطية الخاص بك لدى شركة التأمين الصحي Optima Health. ابحث عن التواريخ الرئيسية في هذا الإخطار، فقد تحتاج إلى اتخاذ أي إجراء قبل حلول المواعيد النهائية للحفاظ على برنامج التغطية الصحية أو الحصول على مساعدة في التكاليف. ولديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك بدون أي تكلفة. يُرجى الاتصال 1-855-687-6260.

Bengali/Bangla:

এই বিজ্ঞপ্তিতে রক্ষণ তথ্য রয়েছে। এই প্রজ্ঞাপনে Optima Health (অপ্টিমা হেলথ)–এর মাধ্যমে দাখিল করা আপনার দরখাস্ত বা কভারেজের উপর ক্ষমপূর্ণ তথ্য রয়েছে। এই বিজ্ঞপ্তিতে উল্লেখ করা ক্ষমপূর্ণ তারিখসমূহ দেখে নিন। আপনার হেলথ কভারেজ বজায় রাখার জন্য বা খরচের বিষয়ে সহায়তা লাভের জন্য আপনাকে নিদিষ্ট সময়সীমার মধ্যে ব্যবস্থা গ্রহণ করতে হতে পারে। বিনা খরচে আপনার মাতৃভাষায় এই তথ্য এবং সহায়তা পাওয়ার অধিকার আপনার রয়েছে। কল 1-855-687-6260.

Chinese (Mandarin):

该通知含有重要信息。本通知含有关于 Optima Health 申请或保险的重要信息。请仔细查看本通知中的关键日期。您需要在截止期之前采取相应的行动，从而保障您的保险继续有效，能够为您提供报销。您有权免费获取信息的中文版，并可以免费获取到相关的中文帮助。請撥電話 1-855-687-6260。

French: Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Optima Health. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-855-687-6260.

German: Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Optima Health. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-855-687-6260.

Hindi:

इस सूचना में महत्त्वपूर्ण जानकारी निहित है। इस सूचना में Optima Health के माध्यम से आपके आवेदन या कवरेज के बारे में महत्त्वपूर्ण जानकारी निहित है। इस सूचना में निहित महत्त्वपूर्ण तिथियों को देखें। आपको लागत के साथ अपने स्वस्थ या कवरेज रखने या सहायता के लिए निश्चित समय सीमा में कार्रवाई करने की जरूरत हो सकती है। आपके पास बिना किसी लागत के अपनी भाषा में इस जानकारी और सहायता को प्राप्त करने का अधिकार है। कॉल 1-855-687-6260

Ibo: Ọkwa a nwere Ozi Dị Mkpa. Ọkwa a nwere ozi dị mkpa maka akwụkwọ anamachọihe ma ọ bụ mkpuchi gị sitere na Optima Health (Ahụike Optima). Chọọ ụbọchị ndị dị mkpa n'ọkwa a. Ị nwere ike ime ihe tupu ụfọdụ ụbọchị iji dowe mkpuchi ahụike gị ma ọ bụ enyemaka n'ụgwọ. Ị nwere ike ikike inweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Kpọ 1-855-687-6260

Korean: 이 공지는 매우 중요한 정보입니다. 이 공지는 옵티마 헬스를 통한 귀하께 적용되는 지원이나 보험에 대한 매우 중요한 정보입니다. 이 공지의 주요 날짜를 찾아보십시오. 귀하께서는 귀하의 건강 보험이나 비용에 관한 도움에 관련된 특정 마감일을 지켜야만 합니다. 귀하께서는 따로 비용없이 귀하의 언어로 이 정보와 도움을 받을 권리가 있습니다. 로 전화하십시오 1-855-687-6260.

Kru/Bassa: Nàùm pò wùdù nà kè kpà dɛ miù. ɔ mò dɛ kpà dɛ bá ni dyí kánà-kánà dyi dɛ Optima Health mú. M̀̀ ti kpà dɛ bè ni dɛ nàùm pò wùdù mú. M̀̀ ti kpà dɛ bè ni dɛ nàùm pò wùdù mú. M̀̀ bè dɛ bè m̀̀ ké nàùm pò pòd̀̀ ò mù pò dyi. ɔ̀̀ jù kè m̀̀ dyi dɛ bèà nyuèn, m̀̀ wíq̀̀ ò mù bì d̀̀ dyi. Wà bì d̀̀ bè wà kè nàùm pò wùdù nà kè`Bàs` wùdù mù pò. Sebel 1-855-687-6260.

Navajo: Díí saad íliinii baa hane'. Naaltsoos-ní'íniíltsoozígíí éí doodago kwe'é Optima Health ník'é'éstí'ígíí bína'ídííkidgo díí kwe'é hazhó'ó baa ákonínízin dooleet. Yoolkáát yéédaá' nich'í' é'élyaago biká'ígíí hádíí'í'jít. Díí ník'é'éstí'ígíí éí doodago béeso da bee níká a'doowó'ígíí bikáa'go da át'ée dooleet áko t'áadoo bee e'e'aahí baa yííkaahgo tsxí'igo hasht'e dííííí níí da dooleet. Bee haz'áanii hó'ó díí kót'éego yaa halne'ígíí bee níká a'doowó'igo dóó t'áá nizaadk'ehjí bee níí hodoonií t'áadoo bá'á h ílíí. 'Átah ánó't'í'ígíí bee baa 'áháyá'agéé bich'í' bibéésh bee hane'í hwééííí. 1-855-687-6260.

Persian/Farsi:

این اعلامیه حاوی اطلاعات مهمی است. این اعلامیه حاوی اطلاعات مهمی درباره درخواست شما و پوشش Optima Health است. به تاریخ های کلیدی عنوان شده در این اعلامیه دقت کنید. ممکن است لازم باشد تا یک تاریخ مقرر خاص اقدام کنید تا پوشش بیمه تان حفظ شود یا در رابطه با هزینه ها به شما کمک شود. شما از این حق برخوردار هستید تا این اطلاعات و هرگونه راهنمایی دیگر را به زبان خودتان و به صورت رایگان دریافت کنید. 1-855-687-6260

Russian: В данном уведомлении содержится важная информация. В данном уведомлении содержится важная информация о Вашей заявке или страховом покрытии в компании Optima Health. Обратите внимание на важные даты, указанные в данном уведомлении. Если Вы хотите продолжать пользоваться мед.страхованием или получить помощь с оплатой, возможно, Вам потребуется принять решение до определенной даты. У Вас есть право на бесплатное получение данной информации и помощи на родном языке. Звоните по телефону 1-855-687-6260.

Spanish: Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Optima Health. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-855-687-6260.

Tagalog: Ang Paunawang Ito ay Naglalaman ng Mahalagang Impormasyon. Ang paunawang ito ay naglalaman ng mahalagang impormasyon tungkol sa inyong aplikasyon o saklaw sa pamamagitan ng Optima Health. Hanapin ang mahahalagang petsa na nakasaad sa paunawang ito. Maaaring kailanganin ninyong gumawa ng hakbang bago sumapit ang ilang partikular na takdang petsa upang mapanatili ang inyong saklaw na pangkalusugan o tulong sa mga gastusin. Mayroon kayong karapatan na matanggap ang impormasyong ito at makakuha ng tulong sa inyong wika nang walang bayad. Tumawag sa 1-855-687-6260.

Urdu:

اس نوٹس میں اہم اطلاع موجود ہے۔ اس نوٹس میں آپ کی درخواست یا Optima Health کے ذریعے کوریج کے حوالے سے اہم اطلاع موجود ہے۔ اس نوٹس میں درج کلیدی تاریخوں کو ذہن میں رکھیں۔ آپ کے لیے ضروری ہے کہ مخصوص ڈیڈ لائنوں سے قبل اس حوالے سے کوئی ایکشن لیں تاکہ آپ کی کوریج برائے صحت اور لاگت کے حوالے سے معاملات طے رہیں۔ آپ اس اطلاع تک رسائی اور بغیر کسی خرچ کے اپنی زبان میں اس بابت جاننے کے لیے 1-855-687-6260

Vietnamese: Thông báo này có thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc về bảo hiểm của quý vị thông qua Optima Health. Quý vị hãy xem những ngày quan trọng trong thông báo này. Quý vị có thể cần đưa ra hành động trước ngày hết hạn cụ thể để duy trì bảo hiểm sức khỏe của quý vị hoặc hỗ trợ thanh toán cho các chi phí. Quý vị có quyền nhận được thông tin và sự hỗ trợ này theo ngôn ngữ mà quý vị muốn mà không phải trả thêm chi phí nào. Xin gọi số 1-855-687-6260.

Yoruba: Àkíyèsí yíí ní Àlàyé Pàtàkì. Àkíyèsí yíí ní àlàyé pàtàkì nípa ohun tí o bèèrè fún tàbí gbígbà itọjú nípasẹ Optima Health. Wo àwọn ọjọ tó ẹ kókó nínú àkíyèsí yíí. O lè nílò láti gbé ẹgbésẹ nípa gbèdẹke kan láti ẹ̀tọ́jú ìlera ẹ̀ tàbí ẹ̀rànw ọ nípa iye òwó. O ní ẹ̀tọ́ láti gba àlàyé yíí àti ìrànwọ́ yíí ní èdè ẹ̀ ẹ̀láisan owó. Pè sórí 1-855-687-6260.