



FILING AN APPEAL FOR COVERAGE OF MEDICAL CARE THAT HAS BEEN DENIED BY OPTIMA MEDICARE HMO

If your request for coverage or payment for a medical item or service has been denied, you can file an appeal with Optima Medicare by completing and returning the Optima Medicare HMO Medical Care Appeal Request Form below. More information about the Optima Medicare medical appeal process is included below and also in your Optima Medicare Evidence of Coverage.

For additional information, you can call the Optima Medicare Appeals Coordinator at 757-687-6404. You can also call Optima Medicare Member Services toll-free at 1-800-927-6048. TTY users should call the Virginia Relay Service at 1-800-828-1140 or 711. You can call during the following times:

- From October 1 - March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET.
- From April 1 - September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET.

To file an appeal, you must do so within 60 days of the date on the letter about our initial decision. We may give you more time if you have a good reason for missing this deadline.

If you need someone to act on your behalf to file an appeal, that person must either have legal authority or be appointed as a designated representative. If someone has legal authority, such as a Durable Power of Attorney or is a court appointed guardian, etc., a copy of this legal document must be sent to us. To have a relative, friend, attorney, doctor, or someone else be appointed as your designated representative, both you and this person must complete, sign, and return the Appointment of Representative Form. You can print this form from the Medicare website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>

A **standard appeal** will be reviewed and a decision made within 30 calendar days of the date your appeal is received for medical care you have not received and within 60 days for care you have already received.

Please mail or fax the completed Optima Medicare HMO Medical Care Appeal Request (or a letter explaining why you think the Plan's decision was incorrect), legal representation documentation or Appointment of Representative Form (if either is needed), and any additional information about your appeal to:

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876
OR
Fax: 757-687-6232
Toll-free Fax: 1-866-472-3920

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You, your doctor or your representative can decide if you need to file a **fast appeal** for care you have not received yet. **Call us** at the phone numbers above to file a fast appeal. If your doctor calls us or provides a written statement to us to explain that you need a fast appeal due to your health, we will automatically give you a fast decision within 72 hours. If you file a fast appeal without support from a doctor, we will decide if your health requires a fast decision.

With your appeal request, you or your doctor should also send us any information we did not have when we made our initial decision on your request for coverage for a medical item or service such as:

- Office notes from physicians that you have seen regarding the services or procedures in question;
- Medical records from hospitals and other health care providers;
- Physician correspondence;
- Physical, occupational, or rehabilitative therapy notes;
- Copies of bills you have received;
- Any additional information you would like the Plan to consider in reviewing your appeal.

If you have difficulty in obtaining information from your provider, please contact the Appeals Department for assistance at one of the above phone numbers.

For more information and help in handling an appeal, you can contact Medicare.

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<http://www.medicare.gov>).



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

OPTIMA MEDICARE HMO MEDICAL CARE APPEAL REQUEST FORM

Today's Date: _____

Member ID # _____ Group Number: _____ Name of Plan: _____

Member's Name: _____

Address: _____

Home #: _____ Work #: _____

Date(s) of Service: _____ Provider/Facility: _____

Please clearly describe the circumstances regarding your request for an appeal of coverage or payment for a medical item or service that we denied. Use additional paper, if needed.

SIGNATURE

DATE



Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Optima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Optima Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Optima Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact:

Optima Health
4417 Corporation Lane, Virginia Beach, VA 23462
1-855-687-6260, 757-552-7116 (Fax)
languagehelp@sentara.com

If you believe that Optima Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sharon Dajon, Section 1557 Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
1-844-801-3779, 757-552-7116 (Fax)
languagehelp@sentara.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator (above) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you are visually impaired and need large print or other assistance to view this document, please contact us at 1-855-687-6260.

Optima Health Alternative Language Options for Notices and other Written Information

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:

ማሳሰቢያ:

አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:

إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجاناً. اتصل بالرقم 1-855-687-6260.

Bengali/Bangla:

লক্ষ্য করবেন: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন- 1-855-687-6260।

Chinese (Mandarin):

注意: 如果您讲中文普通话, 可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:

ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:

ધ્યાન આપો : જો તમે ગુજરાતી બોલી છે તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કોલ કરો.

Hindi:

ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:

CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:

GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:

重要: 日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:

주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.

Kru/Bassa:

YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha l nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນຳໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:

កំណត់សំគាល់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:

SHOOH: Diné Bizaad bee yáníłti'go doo báááh ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'á. Kojjí' hółne' 1-855-687-6260.

Persian/Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:

ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:

ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:

ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:

DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 numaralı telefonu arayın.

Urdu:

توجه دیں: اگر آپ اردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:

CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:

KÉÉRE:

Ti o bá ń sọ èdè Yorùbá, isẹ̀ ìrànlọ́wọ́ èdè wà fún ọ lófẹ̀ẹ́. Pe 1-855-687-6260