Appeal and Grievance Form

Use this form to file an appeal (request for us to reconsider our decision) or grievance (complaint) related to your Sanford Health Plan Medicare Plan (excluding Medicare Supplement). Please type or print in dark ink.

Member Information		
First Name	Last Name	Date of Birth
Address		
City	State	Zip
Sanford Health Plan Member ID#	Home phone	Cell phone
NOTE: You will need to complete the Appointment of representation section of this form if you are completing for the member.		

What is the issue?
Check a box below to tell us what your issue or concern is about: ☐ A medication (prescription drug) ☐ A medical service (medical care or equipment ☐ An issue not related to a specific medical service or medication
Provide the details below:
Service or Medication
Provider (doctor, facility, prescriber) name Have you already received the medical services or medication? ☐ YES ☐ NO
Service Date (MM/DD/YYYY)
Claim number (if applicable)
Please tell us what happened. Be as specific as possible about what happened and who was involved. Include all dates of service and contact with Sanford Health Plan employees, healthcare providers, or pharmacies. You may attach extra pages if you need more space. Be sure to include all pages when you send this form. **What results do you want from us?** (Examples include paying for medical care or a drug, investigating a grievance, etc.) Please tell us below.

What additional documents have you attached?

☐ Receipt(s) ☐ Medical bill(s) ☐ Medical records
☐ Letter from your provider ☐ None ☐ Other:

Does your appeal or grievance need to be expedited?

- Expedited (fast) appeals are only for services that have not been provided yet and only if you and your doctor believe that waiting for a decision under the standard timeframe will place your life, health, or ability to regain function in serious jeopardy.
- Expedited appeals are resolved within 24 hours for part B medications and 72 hours for medical when we receive them. Expedited grievances are reviewed and resolved within 24 hours.

☐ Please check this box if you need an expedited decision.

Appointment of Representation

If you are the member completing this form and acting on your own behalf, you can skip this section. Fill out the section below only if you are not the member and you are submitting the form on behalf of the member.

Note: If you are a provider or legal representative, you will need to fill out a separate Appointment of Representative (AOR) Form.

Section 1: Appointment of representative

I, _____ (Member name) appoint

_____(Representative name) to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance, or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative below.

_____ _____

Signature of Party Seeking Representation (the member) **Date**

Section 2: Acceptance of appointment

I, _____ (Representative name), hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

Representative Information		
First Name	Last Name	Relationship to member
Address		
City	State	Zip
Phone number (with area code)		

_____ _____

Signature of authorized representative **Date**

Timeframes for Responses

Below are the processing timeframes in which you will receive a response to this appeal or grievance.

Type of Appeal or Grievance	Response Time
Expedited (fast) appeal medication or medical service)	72 hours 24 hours (part B)
Standard medication "authorization" appeal **Example**: You need pre-approval for a medication.	7 calendar days
Standard medication "claims" appeal **Example**: You already have the medication.	14 calendar days
Standard medical service "authorization" appeal **Example**: You need pre-approval for a medical service.	30 calendar days
Standard medical service "claim" appeal **Example**: You already received the medical service.	60 calendar days
Expedited (fast) grievance **Example**: We determined that your appeal doesn't qualify as an expedited appeal **or** we've taken an extra 14 calendars days to resolve your appeal and you disagree with these actions.	24 hours
Standard grievance **Example**: You are dissatisfied with the quality of service or care that the plan orprovider gave you.	30 calendar days

Ready to send the completed form?

Medical Services Appeals and Grievances

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109

Fax: 1-605-312-8910

Questions? We're here to help.

If you have questions, please call the toll-free Customer Service number located on the back of the member ID card. Thank you for taking the time to complete this form. If we have more questions, we will contact you.