Important Information about Your Internal Appeal Rights

SANFORD HEALTH PLAN

What if I do not agree with this decision?
You may have the right to appeal any decision not to provide or pay for an item or service or if you think we made an error. File your appeal within 180 Days in writing or by phone from 8:00 a.m. to 5:00 p.m. CT, Monday-Friday. You also have the right to bring a civil action in a court of competent jurisdiction.

Who may file an appeal?
You or your authorized representative (such as a doctor, family member or attorney) may file an appeal. You must sign the Appeal Form, however, if the request is urgent and a doctor files the appeal, your signature is not required.

How do I file an appeal?
Complete the Appeal Form and send it to the address below. Or contact Customer Service to file your appeal over the phone. Appeal information is also available in the Member Portal at sanfordhealthplan.com/memberlogin.

What should I include with my appeal?
Send supporting medical records, doctors' letters or other information that explains why we should pay for this service. Keep copies of all documents and this notice.

How long does the appeal process take?
We must give you a decision within 30 calendar days if you appeal before you receive the service, or within 60 calendar days if you've already had the service.

What if I need an answer right away?
If your situation is urgent under the law, we will review your appeal within 72 hours (24 hours for Members with plans based in Iowa). A situation is considered urgent when waiting the routine appeal timeframe (shown above) could seriously jeopardize your life or health, your ability to regain maximum function; or would subject you to severe pain that cannot be managed without the service or treatment. If your need is urgent, please contact us by phone. You may also file for a concurrent external appeal with your state's insurance department; see other Resources for information.

What happens after I appeal?
If you appeal, people not involved in the first decision will review your case. If we deny your appeal or you do not receive a timely decision, you may be able to ask for an external review by an independent third party who will review the denial and issue a final decision. If you have a Grandfathered Plan (your plan was in place before March 23, 2010), you must file an internal appeal before you request an independent external review. If you are requesting an extension for a previously approved or ongoing service/treatment, your coverage will not be affected during the appeal.

Can I Get Information About My Appeal?
Yes, contact us to request free, reasonable access to copies of all documents of benefits, guidelines, and/or protocols relating to your appeal, billing and diagnosis codes (if you think a coding error may have occurred) or other related documents. A request for denial, diagnosis, or treatment/code information is not considered a request for an internal or external appeal.

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), if you request information regarding medical necessity for the treatment of a mental health and substance use disorder, documents will be provided within 30 business days. This information will include processes, strategies and/or standards used to determine medical necessity.

Other resources:
You may also contact your state's insurance department for assistance:
Iowa: (877) 955-1212
North Dakota (800) 247-0560
South Dakota: (605) 773-3563

Please contact us with any questions about your rights, instructions or for help to file an appeal.

Contact us:
Sanford Health Plan
Attention: Appeals
PO Box 91110
Sioux Falls, SD 57109-1110
Phone: (888) 425-1480 Fax: (605) 312-8910

Appeals & Grievances Department
Phone: (605) 328-6800 Fax: (605) 312-8910
sanfordhealthplan.com

SANFORD HEALTH PLAN

Appeal Form

Member First Name:_____ Member Last Name: _____

Member ID Number: _____ Date of Birth: _____

Provider: _____ Procedure/Service: _____

Date of Service:_____Referral/Claim Number:_____

If another person is completing this appeal for the Member, this section is required.

Name of person filing appeal and title: _____
Person completing form: ☐ Authorized Representative (Family/Caregiver) ☐ Provider/Doctor/Nurse

Address:_____ City:_____State:_____Zip:_____

Phone:_____Fax:_____

Member signature (required): _____

*The Member's consent is required for an appeal to be filed. The Member can physically sign the form or provide verbal consent to their healthcare provider. If verbal consent is provided, date and time the "Member's signature" portion of the form. If the appeal meets the definition of urgent (below), the Member's consent is not required.

Tell us why you do not agree with our decision:

_____

_____

_____

_____

I attest this is an urgent appeal request as waiting the standard timeframe (details on timeframes included in "Important Information about Your Internal Appeal Rights"):

☐ Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function and/or could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state.
☐ Would subject the Member to adverse health consequences without the care or treatment that is the subject of the request in the opinion of the provider with knowledge of the Member's medical or behavioral condition.

Please work with your provider to get medical records to support your request.

☐ Medical records are available within the Sanford Electronic Medical Record.
Date(s) to review include: _____
☐ Medical records attached/included
☐ Pharmacy records attached/included
☐ Other_____

Please send this form, any additional information and documentation for review to:
Sanford Health Plan, Attention: Appeals, PO Box 91110 Sioux Falls, SD 57109-1110
Phone: (605) 328-6800 Fax: (605) 312-8910

Please keep copies of this form and all other documents related to this request.