Priority Health appeal process for Federal Employee Health Benefits (FEHB) members

Inquiry, appeal and expedited review procedure notification*
We hope that you are always happy with the services you receive from Priority Health. If you have any questions or concerns, please call our Customer Service department. Our representatives will help you with your problem as quickly as possible.

Here's how to reach Customer Service:
Hours: Customer Service hours vary depending on your Priority Health plan.
Please visit *priorityhealth.com/contact-us* for your plan specific hours.

Phone: Call the Customer Service number on the back of your ID card.

Online: Send us a secure message by logging into your MyHealth account at priorityhealth.com.
Once logged in, go to your Message Center and then choose Priority Health Mailbox.

If you need help understanding this information please contact Customer Service for free language translator services.

If you are not happy with the answers that our representative has provided, you or someone acting on your behalf, including an attorney, can send us a formal complaint. This formal complaint is called an appeal. You have six months from the date you learn of a problem to file an appeal with us. You can file an appeal to ask us to change a decision about any of the following:

- Benefits (including services determined to be experimental or investigational or not medically necessary or appropriate)
- Eligibility
- Payment of claims (in whole or in part)
- How we've handled payment or coordination of health care services
- Contracts with our providers
- Availability of care or providers
- Delivery or quality of health care services or
- A decision not in your favor. This may include services that have been reviewed by Priority Health and denied, reduced or terminated. It also may include a slow response to a request for a decision from us
- Rescission of coverage

*Priority Health and Priority Health Insurance Company

Appeal process

Here is a summary of the appeal process:

Step 1: Filing an appeal

How do I file an appeal with Priority Health?

Contact our Customer Service department to file an appeal with us. Our representatives will ask you to fill out an FEHB appeal form to tell us about your complaint. They can help you fill out this form. You can include extra information if you wish. You must provide this same information if you are requesting an Expedited Review (see page 3 for criteria for an Expedited Review).

- Your name
- Your signature
- Your address
- Your member and/or beneficiary number
- Your reason for asking for the Internal Appeal
- Anything you want us to look at, such as medical records, doctor's letters or other information that tells us why you need the item or service, and
- If you want a standard or fast appeal (for a fast appeal, tell us why you need one). If you are asking for a fast appeal you will need a doctor's letter that supports why you need this. Call your doctor if you need this information.

Return completed form to:
Customer Service Department
MS 1145, Priority Health
PO.Box 269
Grand Rapids, MI 49501-0269

Please keep a copy of everything you send us for your records.

Who reviews appeals?

The members of the Grievance Committee are Priority Health employees and may include a medical doctor, Review by the Appeal Committee always includes an opinion from a doctor for health issues.

What happens after this review?

After we get your request and any information we need from health care providers or facilities, our Grievance Committee will meet to review your case. We will mail you a written response. If you are not happy with the resolution, you can ask for another review (see Step 2. Office of Personnel Management (OPM) Review).

How long will it take for me to get an answer?

If services have not been received:
We have 72 hours after you make your request to 1) let you know our decision or 2) let you know that we need more information before we can make a decision.

If services have been received:
We have 30 days from the date we receive your appeal request to pay the claim, or write to you explaining that we still deny the claim, or ask you or your provider for more information.

If we request more information:
You or your doctor or other health care provider must send the information we ask for within 60 days of our request. We will then make our decision within 30 days of when we receive your additional information.

What can I do if I'm still not happy with the decision?

You may ask for an external review through the Office of Personnel Management (OPM).

Step 2: Office of Personnel Management review

If you do not agree with our decision, you may ask OPM to review it. You must write OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

How do I request an OPM review?

To request a review, write to OPM at:
United States Office of Personnel Management,
Healthcare and Insurance,
Federal Employee Insurance Operations
Health Insurance
FEHB 3
1900 E Street, NW
Washington, DC 20415

What information does OPM need?

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure
- Copies of document that support your claim
- Copies of all letters you sent to us about the claim
- Your daytime phone number and the best time to call
- Your email address, if you would like to receive OPM's decision via email.

What does OPM do when I send them this information?

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days.

What happens after the review is done?

If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

You may not file a lawsuit until you have completed the disputed claims process.

Priority Health expedited review (emergency review)

Priority Health will follow a faster review process when there is an emergency.

How long does this process take?

We will make a decision within 72 hours (three days) from the time we get your request. This timeline begins when we receive your request. During non-business hours, you can leave a message at 800.446.5674 (toll free) to make a request.

When can I ask for an expedited review?

The faster process will be followed when you file a request (verbally or in writing) when the normal time to review your case (Step 1 of the appeal process) would:

- Put your life in danger
- Interfere with your full recovery, or
- Delay treatment for severe pain (must be confirmed by your doctor)

Notice of Nondiscrimination and Language Assistance Services

Priority Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Priority Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Federal law requires that we provide you with this Notice of Nondiscrimination and Language assistance services.

Free aids and services

Priority 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)

Priority Health 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 Priority Health customer service by calling the number at the back of your membership ID card (TTY users call 711).

To file a civil rights grievance

If you believe that Priority 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:

Priority Health Compliance Department
Attention: Civil Rights Coordinator
1231 East Beltline Ave NE
Grand Rapids, MI 49525-4501
Toll free: 866.807.1931 (TTY users call 711) Fax: 616.975.8850
PH-compliance@priorityhealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Priority Health Civil Rights Coordinator 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 ***ocrportal.hhs.gov*** 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

800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at *hhs.gov/ocr/office/file/index.html.*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم:711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請撥打會員卡背面的客服電話 (TTY: 711）。

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܣܘܪܝܝܐ (ܐܬܘܪܝܐ) ، ܡܨܝܬܘܢ ܩܒܠܝܬܘܢ ܝܘܠܦܢܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܐܢ ܡܡܨܠܝܬܘܢ ܡܢܘܢ ܠܒܪ ܡܢ ܡܢܝܢܐ ܕܡܫܡܫܢܘܬܐ ܕܥܡܝܠܐ ܥܠ ܡܢܝܢܐ ܕܐܝܬܠܗ ܒܓܒܐ ܠܒܪܝܐ ܕܟܪܛܝܣ ܕܗܕܡܘܬܐ ܕܡܫܘܬܦܘܬܐ. (TTY: 711)

CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin hãy gọi tới số điện thoại của bộ phận dịch vụ khách hàng có ở mặt sau thẻ ID thành viên của quý vị. (TTY: 711).

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Ju lutem kontaktoni qendrën e shërbimit për klient në pjesën e pasme të ID kartës tuaj të anëtaresimit (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 멤버쉽 ID카드의 뒷면에 있는 고객 서비스 번호로 전화해 주십시오. (TTY: 711)

লক্ষ্য করুনঃ আপনি বাংলায় কথা বলতে পারলে আপনার জন্য নিঃখরচায় ভাষা সহায়তা সেবা সুলভ রয়েছে। অনুগ্রহ করে আপনার সদস্যপদ আইডি কার্ডের পেছনে থাকা গ্রাহক সেবা নম্বরে কল করুন। (TTY: 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer telefonicznej obsługi klienta wskazany na odwrocie Twojej legitymacji członkowskiej (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienste zur Verfügung. Bitte rufen Sie die Kundendienstnummer auf der Rückseite Ihrer Mitgliedskarte an. (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero sul retro della tessera identificativa di membro. (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。メンバーシップIDカードの裏面にあるお客様サービスセンターの番号までお電話にてご連絡ください。(TTY: 711).

ВНИМАНИЕ! Если Вы говорите на русском языке, то Вам доступны услуги бесплатной языковой поддержки. Пожалуйста, позвоните в службу поддержки клиентов по номеру, указанному на обратной стороне Вашей идентификационной карточки участника (телетайп (TTY: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Molimo nazovite broj službe za korisnike na pozadini vaše članske iskaznice (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog,mga serbisyo ng tulong sa wika, ng libre, ay available para sa iyo. Pakitawan ang numero ng customer service sa likod ng iyong ID card ng pagiging miyembro. (TTY: 711).