



S E N T A R A™

Sentara Behavioral Health Services
4417 Corporation Lane, Suite 250
Virginia Beach, Virginia 23462

Tel: 757.552.7500 Fax: 757.552.7176
www.SentaraBehavioralHealth.com

Dear Member:

Sentara Behavioral Health Services (SBHS) is a Managed Behavioral Healthcare Organization that administers behavioral health benefits for Optima Health Plans. Thank you for your request for information regarding the SBHS Adverse Benefit Determination Appeal Process. Please refer to your member materials for a detailed description of your Plan's appeal procedures. Enclosed you will find the following information to help guide you should you choose to file an appeal.

- Appeal Request Form
- Designation Authorization Form (To designate someone such as a provider or family member to act on your behalf in filing an appeal, including when you are 14 years or older and another person, e.g. parent, guardian is to act on your behalf)
- Authorization to Disclose Protected Health Information Form (This is also called a Release of Information and is needed so that we can assist you in obtaining pertinent clinical information, when required, from the provider or other sources)

To initiate the Appeal Process, please submit your request in writing to:

**Sentara Behavioral Health Services
APPEALS
4417 Corporation Lane
Suite 250
Virginia Beach, Va. 23462
OR
Facsimile: (757) 552-7176
Toll Free Facsimile: (888) 576-9675**

You or your authorized representative has the right to submit written comments, documents, records, or any other information relevant to your case. If you have difficulty in obtaining this information, please contact Appeals for assistance. Relevant information includes:

- The Appeal Request Form describing the services or procedures requested and an explanation of why you feel the SBHS decision was incorrect;
- Records from providers and hospitals that provided treatment regarding the services or procedures in question;
- Provider correspondence;
- Copies of bills you have received;
- Copies of Explanation of Benefits you have received;
- Any additional information you would like SBHS to consider in reviewing your appeal.

Upon SBHS' receipt of your written request, you will have ten (10) days to submit any additional clinical information. Any documentation received after the 10th day may not be considered in your appeal review.

Your continued satisfaction with SBHS is our primary concern. In you have any questions regarding your appeal, please contact Appeals at (757) 552-7174 or 1-(888) 576-9675 toll free.

Sincerely,
C. Michael Powell, LPC
SBHS Appeals Manager

**Sentara Behavioral Health Services
4417 Corporation Lane
Suite 250
Virginia Beach, Va. 23462**

APPEAL INSTRUCTIONS

Upon receipt of the Appeal Form and any additional information submitted, your request will be reviewed by a person or persons who were not involved in the initial denial. The appeal review will take into account all comments, documents, records, and other information submitted by you or on your behalf relating to the claim, without regard to whether such information was submitted or considered in the initial determination.

Once your initial written request is received by Sentara Behavioral Health Services (SBHS), you will have ten (10) days to submit any additional information. Any documentation received after the 10th day may not be considered in your appeal review. New information may be submitted:

By Mail/In Person:	SBHS Appeals 4417 Corporation Lane, Suite 250 Virginia Beach, Va. 23462	By facsimile: 757-552-7176 888-576-9675
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Your appeal will be reviewed and a decision made within 30 calendar days for pre-service claims and 60 days for post-service claims. For more details, please refer to the Appeals Procedure section of your member materials.

Expedited Appeals-You or your provider may request an expedited appeal if SBHS were to use its normal appeal procedure for making a decision, it would (1) seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (2) in the opinion of a provider with knowledge of the Member's medical condition would subject the member to server pain that cannot be managed without the care or treatment that is the subject of this claim. If you believe you need an expedited appeal, please contact Appeals at 757-552-7174. If your request does not qualify as an expedited appeal, the standard appeal process will apply.

Additional Resources-The Office of the Managed Care Ombudsman is available to help Virginia consumers who experience problems with, or have questions about managed care. The Ombudsman can assist Members in understanding and exercising their rights of appeal of Adverse Benefit Determinations. There are several ways to contact the Ombudsman:

Write: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, Va. 23218

Telephone: 877-310-6560 Toll free

Richmond Metropolitan Area: 804-371-9032

E-mail: Ombudsman@scc.state.va.us

Sources for Additional Information-If you have been unable to contact or obtain satisfaction from SBHS, you may contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 800-955-1819.

You may also contact the U.S. Department of Labor, Pension and Welfare Benefits Administrator at 866-444-3272 or visit their website at www.dol.gov.

The Office of Personnel Management (OPM) is available to review disputed claims for FEHB Members. FEHB Members should

write to OPM within 90 days of the date of the SBHS letter of Final Adverse Benefit Determination:

Write: Office of Personnel Management
Office of Insurance Programs
Contracts Division 2
1900 E Street, N.W.
Washington, D.C. 20415-3620

Sentara Behavioral Health Services
4417 Corporation Lane
Suite 250
Virginia Beach, Va. 23462

SBHS Authorization to Disclose Protected Health Information

I hereby authorize

To release to

(Specific person/class of persons/organization)

(Specific person/class of persons/organization)

(Address)

(Address)

(City, State, Zip)

(Phone #)

(City, State, Zip)

(Phone #)

Information contained in the member file of:

(Name of Member)

(Date of Birth)

(Member ID Number)

(Date(s) of Service)

For the specific purpose of: (If you do not wish to state a purpose please state "At the request of the individual.")

Specific Information Requested (check all that apply):

Claim(s) Data (Member Profile)

Problem list

Diagnostic Studies

Medication List

Discharge Summary

Complete Medical Record

Most Recent History and

Physical

Lab data

Most Recent Discharge

Summary

Consultation Reports

Progress / Clinical Record

Office Notes

Psychiatric & Psychological Information

Other _____

I understand that by signing this form I give permission to release the specific information requested designated above to the designated recipient and agree to hold both the releaser and the recipient harmless for complying with this authorization. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to

contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months. 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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that my health plan may condition my enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to my enrollment if the authorization sought is for the health plan's eligibility or enrollment determinations relating to me or its underwriting or risk rating determinations, and the authorization is not for use or disclosure of psychotherapy notes. Complete only if SBHS requested the disclosure (circle appropriate): SBHS will/ will not receive remuneration for this disclosure.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality laws. If I have questions about disclosure of my health information, I can contact Sentara Privacy Office. 757-857-8494.

(Signature of Patient or Legal Representative) (Date)

(If signed by Legal Representative, relationship to Member) (Signature of Witness)