Optima Behavioral Health Services
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, Virginia 23466-2876
www.optimabehavioralhealth.com

Dear Member:

Thank you for your request for information regarding Optima Health's Adverse Benefit Determination Appeals Process. Please refer to your member materials for a detailed description of the Plan's appeal procedures. Enclosed you will find the following information to help guide you if you should choose to file an appeal.

- Appeal Request Form
- Designation Authorization Form (To designate someone such as a physician 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 for Use or Disclosure of Medical Information (This is also called a Release of Information and is needed so the Plan can assist you in obtaining pertinent medical information from the practitioners or providers).

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

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

You or your authorized representatives have 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 the Appeals Department for assistance.
Relevant information includes:

- The Appeal Request Form describing the services or procedures requested and an explanation of why you feel the Plan's decision was incorrect;
- 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.

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

Your continued satisfaction with the Plan is our primary concern. If you have any questions regarding your appeal, please contact the Appeals Department at (757) 687-6404.

APPEAL INSTRUCTIONS

Upon receipt of the Appeal Form and any additional information submitted, your request will be reviewed by a person or persons 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 the Plan, 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: Optima Health Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876

In person: Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462

By facsimile: 757-687-6232
1-866-472-3920

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 physician may request an expedited appeal where if the Plan 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 physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If you believe you need an expedited appeal, please contact the Appeals Department at 757-687-6404. If your request does not qualify as an expedited appeal, the standard appeal process will apply.

SOURCES FOR ADDITIONAL INFORMATION

If you have been unable to contact or obtain satisfaction from the Plan, you may contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 1-800-955-1819.

You may also contact the U.S. Department of Labor, Pension and Welfare Benefits Administration at 1-866-444-3272 or visit their website at www.dol.gov.

The Office of Personnel Management (OPM) is available to review disputed claims for **FEHB Members only**. FEHB Members should write to OPM within 90 days of the date of the Plan's letter of Final Adverse Benefit Determination:

Write: Office of Personnel Management
Office of Insurance Programs
Contracts Division 2
1900 E. Street, NW
Washington, DC 20415-3620

The Managed Care Ombudsman is available to help Virginia Consumers who experience problems with, or have questions about managed care. The Managed Care Ombudsman can assist Members in understanding and exercising their rights of appeal of adverse decisions.

Write: Office of the Managed Care Ombudsman

Bureau of Insurance

P.O. Box 1157

Richmond, VA 23218

Telephone: Toll-Free: 1-877-310-6560

Richmond Metropolitan Area: 1-804-371-9032

E-Mail: ombudsman@scc.virginia.gov

OptimaHealth

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

APPEAL REQUEST FORM

Today's Date: ______________________________

Member ID #____________________Group Number: ____________ Name of Plan: _____________

Member's Name: ____

Subscriber's Name: ____

Address:____

Home #:_________________________________ Work #:_________________________________

Date(s) of Service: _________________________ Provider/Facility: ________________________

Please clearly describe the circumstances regarding the member's request for an appeal of an adverse determination using additional paper, if needed:

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DATE **SIGNATURE**

2009

Optima Behavioral Health Services
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876

A member has the right to designate an authorized representative, such as a provider or family member, to act on his or her behalf in filing an appeal of an Adverse Benefit Determination. This authorization may be granted for a particular event or date of service after which time the authorization is revoked, or may be granted for any present or future claim for health care benefits. Explanation of Benefit statements will not be directed to an authorized representative, but will continue to be sent to the Member. **Due to the privacy of protected health information, this form must be completed and returned when the member is 14 years or older and another person (e.g. parent, guardian) is acting on his or her behalf.** To designate an authorized representative, please complete this form and return to Optima Health Appeals Department.

Optima Health Designation Authorization Form
Appeals Department

Member Name: ____

Member ID#: ______________________________ Date of Birth: ____________

Health Plan:
- ☐ Optima Health Plan (OHP)
- ☐ Optima Medicare PPO
- ☐ Commonwealth of Virginia
- ☐ Optima Health Insurance Co. (OHIC)
- ☐ Optima Family Care/FAMIS

I hereby designate: ____
Name Relationship

____
Address

____
City, State, Zip

to act on my behalf in pursuing a claim for benefits or an appeal of an adverse benefit determination.

- ☐ This consent is valid for _____________ days (Consent is valid for **180 days** unless noted otherwise).
- ☐ Consent is valid until revoked by me.

I, the undersigned, understand that I may revoke this consent at any time. Also, upon fulfillment of the above stated purpose, 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, and that this authorization shall be valid for a period of 180 days, unless otherwise noted above.

(State date, event, or condition of expiration)

Signed _______________________________ Date ___________________________

INSTRUCTIONS FOR AUTHORIZATION COMPLETION

1. Please **PRINT** information in pen so it is easy to read.

2. Do not skip any steps. Fill all information in as completely as possible.

3. Step 2, #4: information to be disclosed (Other): use specific descriptions such as:

   Claims information from ________ to _______
   Clinical information from ________ to ________
   Designated Record Set from ________ to ________
   Appeal/review information from ________ to ________
   All claims information
   All clinical information
   Complete Designated Record Set
   All appeal/review information

4. Step 2, #5: purpose for the disclosure (other) use specific description such as:

   Coordination of care/case management
   Appeal or grievance resolution
   Eligibility or enrollment determination
   Evaluation of fitness for duty
   Resolution on a Disability claim
   Resolution of a Workers' Comp claim
   Treatment and follow-up
   Research
   Marketing
   Legal, i.e., subpoena

5. You must sign and date #9

QUESTIONS: Call Member Services for any questions or concerns regarding this authorization form.

Optima Health

Authorization for Use or Disclosure of Medical Information

Read this information first:

You should complete this form if you wish to authorize Optima Health to use or disclose your medical information to persons who may or may not directly be involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) two (2) years from the date signed; or (3) the date you withdraw your permission.

*****Mail this form to: Optima Health, P O Box 62876, Virginia Beach 23466-2876.**

Step 1: Complete the demographic information for the person receiving services:

1. ______________________________ **2.** ___ ___/ ___ ___/ ___ ___ ___ ___

Name **Date of Birth**

3. ______________________________

Member ID # or SSN #

Step 2: Tell us what medical information may be used or disclosed:

4. Check the appropriate box to indicate what information may be used or disclosed:

- **a. My entire record** ☐
- **b. Other (see instructions)** ☐ ______________________________

5. Check the appropriate box to indicate the purpose of the use or disclosure:

- **a. At my request** ☐
- **b. Other (see instructions)** ☐ ______________________________

Step 3: Tell us whom you are authorizing to use or receive your medical information:

6. ______________________________

Name of Authorized Person

7. ______________________________

Address of Authorized Person

8. OPTIONAL: Authorization termination date:
__ __/ __ __/ __ __ __ __

Step 4: Complete your acknowledgement that you understand that:

- **You have the right to review the information that is being used or disclosed;**
- **You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;**
- **The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by the federal privacy laws;**
- **You have a right to revoke this authorization at any time by completing and sending to Optima Health a "Revocation of Authorization" Form and**
- **You have a right to receive a copy of this signed authorization.**

9. ______________________________ ______________

Person receiving services or Designated Representative's signature** **Date**

10. ______________________________

Designated Representative's relationship **

*****Attach a copy of the appropriate legal document granting authority***