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, in the Member Portal or by phone from 8:00 a.m. to 5:00 p.m. CT, Monday-Friday. If a determination is not in your favor, you 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 healthcare practitioner, family member or attorney) may file an appeal. You or your attending healthcare practitioner may file an appeal in writing or verbally.

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 the Appeal Form?
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 15 calendar days.

What If I Need an Answer Right Away?
If your situation is urgent under the law, we will review your appeal within 72 hours. 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; see "Other Resources" for information.

What Happens Next?
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. Minnesota Members have the right to obtain a second opinion at no charge from a Practitioner not associated with Sanford Health Plan for adverse determinations of mental health or substance abuse claims.

Other Resources:
You may also contact the Minnesota Department of Health at (800) 657-3916.

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

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:_____

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.