Priority Health appeal process for individual policyholders

Inquiry, appeal and expedited review procedure notification*
Your confidence in us and your satisfaction with our services is very important. We understand that there will be times when you will have a concern or a problem you want us to address. As a first step, we ask that you contact our Customer Service department. Our representatives will help you with your concern as quickly as possible.

Here's how to reach Customer Service:
Hours: 7:30 a.m. – 7:00 p.m. Monday through Thursday
9:00 a.m. – 5:00 p.m. Friday
8:30 a.m. – 12:00 p.m. Saturday

Phone: 800.528.8762
616.464.8830

Online: Send us a secure message through our website at *priorityhealth.com*.

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

If you are not satisfied with the answers provided to you by Customer Service, you can then formally request Priority Health change the response or decision provided. You or someone acting on your behalf, including an attorney, can send us a formal complaint called an appeal. You must file an appeal within 180 days from the date you learn of the decision you do not agree with.
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 or cancellation of coverage
- 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
- 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.

Appeal process
Here is a summary of the appeal process:

- **Step 1: Filing an Appeal with Priority Health**. If you are not satisfied with the outcome of Step 1, you can choose to proceed to Step 2.
- **Step 2: Requesting an External Review.** (State of Michigan)

If your request involves a medical emergency, refer to the Expedited Review section.

**Priority Health and Priority Health Insurance Company*

Continued >

Step 1: Filing an appeal with Priority Health

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 appeal form to tell us about your complaint. They can help you fill out this form. You can include additional information if you wish. You must provide this same information if you are requesting an Expedited Review (see page 4 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.

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

Who reviews appeals?
The person or persons who review your appeal are not the same individuals who were involved in the initial decision (or determination). Review by the Appeal Committee always includes an opinion from a doctor for medical issues. The doctor is in the same or related specialty that may treat the medical issue being reviewed.

What happens during this review?
After we receive your appeal and have collected all relevant information from health care providers or facilities, our Appeal Committee will then review your case. You will be provided with the date and time prior to your review. You will also be given a full description of what will happen during the review, as well as a copy of the materials that will be reviewed by the Appeals Committee free of charge. You and/or a representative can also choose to participate during the review, where you will have the chance to speak to the Appeal Committee members.

What happens after this review?
The Appeal Committee will make a decision and we will mail you a written response within five full business days of the review.

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

If services have not been received (this means that you have not yet received the medical services you are filing an appeal for): Review must be completed with a final determination made within 30 calendar days after we receive your appeal form. The 30 calendar days do not include any days you or your representative may delay the process.

If services have been received (this means you have already received the medical services you are filing an appeal for):
Review must be completed with a final determination made within 60 calendar days after we receive your appeal form. The 60 calendar days do not include any days you or your representative may delay the process.

If we receive your appeal form during non-business hours, we count the time of receipt as the next business day.

What can I do if I'm still not satisfied with the decision?
You may ask for an external review through the Michigan Office Department of Insurance and Financial Services (DIFS).

Step 2: Requesting an External review (State of Michigan)

If you ask for a review with the Department of Insurance and Financial Services (DIFS), they will first determine:

- If your request is complete.
- If your request is accepted for external review.

If accepted for external review and your issue is about your health, your request will be assigned to an Independent Review Organization (IRO). You will not pay for any of the costs of the independent review. If your issue is not about your health, DIFS will review and decide your issue itself.

How do I request an external review?
To request a review, you need to complete the form provided by Priority Health and contact DIFS. This form can also be found on the DIFS website listed below. This must be done no later than 127 days after you get a notice of a decision not in your favor from Priority Health. If Priority Health does not meet the timeline requirement for Step 1 of the internal appeal process, you may also request a review by DIFS. If you have given Priority Health more time for a decision, you may not request a review until Priority Health has made its decision.

What information does DIFS need?
A Health Care-Request for External Review Form must be sent to DIFS. This allows Priority Health and doctors to tell DIFS about your personal health information. You may also give other information about your case.

Here's how to contact DIFS:
Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220
530 W. Allegan Street, 7th floor
Lansing, MI 48909-7720
Fax: 517.284.8838
Phone: 877.999.6442
www.michigan.gov/difs

What does DIFS do when I send them this form?
DIFS tells Priority Health that they received your request for review. Within five business days, DIFS does a review to decide these things:

- If you or your dependent are or were covered under Priority Health.
- If the services seem to be a covered benefit.
- If you have gone through the Priority Health appeal process (unless it is not required).
- If you have given all the information you would like to be reviewed.
- If you have sent in the necessary form.

When this review is done, DIFS will tell you if your request is complete and if it has been accepted. If accepted, DIFS must:

- Tell you that you may send in additional information within seven business days.
- Tell Priority Health that your review request has
  been accepted.

If your review is not accepted, DIFS must tell you why. If it is not accepted due to incomplete information, DIFS must send you a letter to tell you what is missing.

What happens during the review process?
If your review request is accepted, an IRO is asked to perform the review and to make a recommendation to DIFS within 14 calendar days.

- DIFS gives the information you sent in to the IRO and to Priority Health.
- You and Priority Health will both receive letters telling the name of the IRO that will do the review. You have seven business days to send additional information to the IRO.
- Within seven business days after the letter, Priority Health must give the IRO any documents or information used to make the decision not in your favor. If Priority Health does not do this in seven business days, DIFS can reverse Priority Health's decision.
- Please note that reviews about medical issues are reviewed by an IRO. Reviews about non-medical contractual issues may be reviewed by the Director of DIFS and/or an IRO.

What does the IRO look at during the review?

- Medical records related to the case
- The doctor or health care professional recommendations
- Opinions from similar health care professionals and other documents sent in
- Terms of benefit plan coverage
- Most appropriate practice guidelines
- Clinical review criteria developed by Priority Health that relates to your case

What happens after the review is done?

- The IRO must send a recommendation to the Director of DIFS within 14 calendar days.
- The Director reviews it to make sure it agrees with the terms of coverage.
- The Director tells you and Priority Health of the decision within seven business days after getting the recommendation [DIFS generally takes longer than seven days to make a decision].
- If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

Priority Health expedited review (emergency review)

Priority Health will follow a faster review process when there is a medical 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 877.954.1035 (to

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)

What happens after this review?
We will tell you by telephone right after we make the decision. We will also send a letter telling you about the decision within two business days after the decision. If you are not happy with the final decision, you may appeal to DIFS within 10 days after you receive the final decision about your expedited review. DIFS will follow a faster review process when there is an emergency.

When can I ask for DIFS expedited review?
An expedited review by DIFS may be asked for if:

- Your doctor tells DIFS by phone or in writing that
  Priority Health's review time would put your life in
  danger, or would interfere with your full recovery, and
- You have already asked for an expedited review
  by Priority Health.
- Note: Your expedited, external review by the State
  can happen at the same time you are using the internal Priority Health appeals process for urgent care and ongoing treatment.

State of Michigan expedited review (emergency external review)

How do I ask for the State's expedited review?
Priority Health will provide you with a Health Care-Request for External Review Form to start this process. You may also contact DIFS to get this form or get it from DIFS website.

How long does this process take?
DIFS expedited review will be done within 72 hours (three days) from the time DIFS gets it from you.

What information does DIFS need?
A Health Care-Request for External Review Form must be turned in to DIFS. This allows Priority Health and doctors to tell DIFS about your personal health information. You may also give other information about your case.

What happens during DIFS expedited review?
Here's what happens at DIFS when you send in your request:

- DIFS tells Priority Health and decides if the request meets the requirements for an expedited external review.
- If accepted, your case is reviewed by an IRO, and they will determine if you need to complete a Priority Health expedited internal review first. If this occurs, it will be sent back to follow the Priority Health process.
- If accepted for an expedited external review, Priority Health must provide all paperwork and information to the IRO within 12 hours after we receive notice.
- The IRO must make a recommendation within 36 hours after getting the request.
- The Director reviews the recommendation from the IRO. The Director makes a final decision within 24 hours after receiving the recommendation.

What happens after this review?
If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

Who decides which IRO reviews the requests?
The Director of DIFS must approve IROs. IROs cannot be owned or controlled by, be subsidiary of or in any way owned or controlled by or exercise control with the health plan; a national, state or local trade association of health benefit plans; or a national, state or local trade association of health care providers.

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.

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)

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).

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 ܐܚܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܣܘܪܝܝܐ (ܐܬܘܪܝܐ) ، ܬܚܝ ܒܬܘܢ
ܡܨܠܒܬܘܢ ܝܠܦܢܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܢܐܝܬ. ܐܢ ܡܫܟܠܡܘܢ ܗܘܢ ܠܚܕ ܡܢ
ܡܢܝܢܐ ܡܫܡܫܢܐ ܕܝܠܦܢܘܬܐ ܥܠ ܦܬܬܐ ܕܐܝܠܗ ܒܠܒܪܐ ܠܒܛܩܐ ܕܗܝܘܬܐ ܕܗܕܡܘܬܐ
ܕܗܕܡܘܬܐ. (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).

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).