Priority Health appeal process for individual policyholders

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: 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: 888.389.6645
       616.464.8830

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

If you are not happy with the answers that our representative has provided, you or someone acting on your behalf can send us a formal complaint. This formal complaint is called an appeal. You have two years 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

Continued >
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 appeal form to tell us about your complaint. They can help you fill out this form. You can include extra information if you wish.

Who reviews appeals?
The members of the Appeal Committee may include Priority Health employees, Priority Health members, local employers that offer Priority Health to their employees and physicians from the Priority Health network. 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, the Appeal Committee will then review your case. We will tell you the date, time and place where the review will be held. We will give you this information after we receive your request for appeal. We will explain what will happen during the review. You also can be at the review, have someone represent you at the review, or participate in the review by telephone. You will get a copy of the material that will be reviewed by the Appeal Committee free of charge. During the review you or your representative will have the chance to talk to the Appeal Committee.

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

Our Appeal Committee meets every 14 days. It may meet more often to meet these timeframes.

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

Step 2: External review

If you ask for a review with 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 60 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
Health Plans Division
611 West Ottawa, 3rd Floor
P.O. Box 30220
Lansing, MI 48909-7720
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 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 Commissioner of DIFS within 14 calendar days.
• The Commissioner reviews it to make sure it agrees with the terms of coverage.
• The Commissioner 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 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 877.954.1035 (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)

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.

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 Commissioner reviews the recommendation from the IRO. The Commissioner makes a final decision within 24 hours after receiving the recommendation.
• Clinical review criteria developed by Priority Health that relates to your case

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 Commissioner 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.

State of Michigan expedited review (emergency external review)

How do I ask for the State’s expedited review?

How do I ask for DIFS 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.