Appeal and/or Grievance Process

Definitions:

Appeal: An appeal is the action you take if you disagree with a coverage or payment decision made by HealthSpan. HealthSpan will respond to your appeal within 30 calendar days. There are some situations that qualify for a “fast or expedited” appeal. If a service has already been provided, it does not qualify for a fast appeal. Please contact Customer Relations at 1-216-621-7100 or review your Evidence of Coverage to learn more about that process.

Grievance: A grievance is any complaint, **not involving a request to provide or pay for items or service**, expressing dissatisfaction with how HealthSpan provides health care services.

Timeframes:

- Medicare members have 60 days, following an event or denial notification, to either submit an appeal or grievance
- Federal employees have six months, following an event or denial notification, to either submit an appeal or grievance
- All other members have 180 days, following an event or denial notification, to either submit an appeal or grievance.

Forms: You are not required to submit your appeal request on a specific form; however, for your convenience, we are providing a template to use when submitting your appeal or grievance. REMEMBER, all forms must include your signature.

Appointment of Representative: You can appoint someone to file an appeal or grievance for you by completing and submitting a signed Appointment of Representative Form (AOR Form). Both YOU and YOUR APPOINTED REPRESENTATIVE must sign this form. Please feel free to contact Customer Relations or review your Evidence of Coverage to learn more about the Appointment of Representative requirements.

Appointment of Representative Form: please complete the Medicare Appointment of Representative Form your convenience. Please complete sections 1 and 2 and submit with your appeal request.

Appeal or Grievance Request Form

To assist you with filing an appeal or grievance, please feel free to complete this form and fax or mail to:

HealthSpan Appeals Unit
PO Box 93764
Cleveland, Ohio 44101-5764
Fax #: 1-216-635-4453

Note: This form is not required; however, all appeal/grievance requests must include the appropriate signatures.

Name and Address of member:
Birthdate of member:
Member ID (if available):
Name and Contact Phone Number of person submitting the appeal if parent/guardian OR Appointed Representative (see page 1 for requirements):
DENIED service (or item) you wish to appeal:
Date service was provided (if applicable):
Reason you feel Healthspan's coverage information indicates service should be provided:

_____ _____

Signature of Member or Authorized Rep **Date**