STATE HEALTH BENEFITS PROGRAMS APPEAL FORM

Persons enrolled in COVA Care, COVA Connect, COVA HDHP (High Deductible Health Plan), Advantage 65, Advantage 65 with Dental/Vision, Option I or Option II may use this form to appeal to the Director of DHRM on matters of eligibility, regardless of the State plan in which the appellant is enrolled. ***To be considered a valid appeal, the Director must receive it within four (4) months of the final adverse decision of the Plan Administrator.***

NOTE: Matters in which the sole issue is disagreement with policies, rules, regulations, contract or law cannot be appealed to DHRM. The decision of the Plan Administrator is final in these cases.

Your Name _____ **Patient Name** _____
Name of Enrolled Employee_____ **Member ID #** _____
Address _____
City _____ **State** _____ **Zip** _____
Home Phone (___)_____ **Business Phone** (___)_____
Service or Supply requested_____ **Date of Service** _____
Name of Physician, Hospital, or Other Health Care Provider _____

CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR THE APPEAL:

- ☐ Believe the claim was for a covered service and should not be denied for payment.
- ☐ Believe a service met the Health Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered service, though denied, reduced or terminated.
- ☐ Believe a service was medically necessary, though denied as experimental/investigational.
- ☐ Eligibility or "Other" Issue.

PLEASE DESCRIBE THE REASON(S) YOU ARE FILING THIS APPEAL:

_____
_____
_____

WHAT SPECIFIC REMEDY DO YOU SEEK IN FILING THIS APPEAL?

_____
_____

DOES THIS QUALIFY FOR AN EXPEDITED APPEAL (please refer to your Member Handbook) AND ARE YOU REQUESTING AN EXPEDITED APPEAL? ☐ Yes or ☐ No

PLEASE ATTACH DOCUMENTS RELEVANT TO YOUR APPEAL. For example: Explanation of claims processed, other correspondence from plan, letter from your physician, bill from your health care provider, the plan administrator's final denial, or any other information you want considered. Are documents attached? ☐ Yes or ☐ No

APPEALS TO THE DIRECTOR OF THE DEPARTMENT OF HUMAN RESOURCE MANAGEMENT should be addressed as follows:

Director, Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, Virginia 23219-3657
Please mark the envelope **Confidential – Appeal Enclosed**

MEMBER'S SIGNATURE _____ **DATE** _____

This form must be signed by the Member. If this form is being signed by anyone other than the Member, please complete the next section. To be completed only if the member wishes to appoint someone to represent them during the appeals process. **NAME OF AUTHORIZED REPRESENTATIVE:** _____

NOTE: For appeals related to **medical or mental health and substance abuse claims**, you must submit a completed **HIPAA Authorization Form** to DHRM before the appeal can be processed. The form is available on the DHRM Website at www.dhrm.virginia.gov under Appeals or from your Benefits Administrator.

Health Benefits Plan for State and Local Employees
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

EMPLOYEE/RETIREE
Name: _____ID Number: _____
MEMBER
Name: _____ ID Number: _____
Date of Birth: _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

_____
_____

WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?

_____
_____

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION?

_____
_____

REASON THE INFORMATION WILL BE USED OR DISCLOSED [if the member initiates the authorization, the statement "at the request of the individual" is sufficient]:

_____
_____

EXPIRATION DATE OR EVENT: _____

Notice to Member

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Office of Health Benefits, 12th Floor, Privacy Official, 101 N. Fourteenth St., Richmond VA 23219. The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed above, if we have already taken action in reliance on this authorization. Also, if this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services.

You do not have to sign this authorization to receive payment, to enroll in Health Benefits Plan for State and Local Employees' health benefit plan, or to be eligible for benefits, except:

If this authorization is sought is for the purpose of determining your eligibility for benefits or enrollment, then you must authorize the Plan to obtain the necessary information or the benefits or enrollment may be denied.

Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a employee health benefit plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

Signature: _____ **Date:** _____

If this authorization is signed by someone who is not the member listed at the top of this form, provide a description of the signer's authority to act for the member. _____
_____