

Important Information About Your Internal Appeal Rights

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, call one of the numbers listed under “**Get Help & more information.**”

You Have the Right to Appeal

If you have charges listed under “Amount Non-Covered” in your Explanation of Benefits (EOB) or you disagree with how we decided your benefits, you have the right to ask Sanford Health Plan to review our decision by asking for an **appeal** within **sixty (60) days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If You Want Someone Else To Act for You

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call (800) 499-3416 to learn how to name your representative. Both you and the person you want to act for you must sign and date a statement confirming this is what you want and return to Sanford Health Plan. You may also indicate this on the enclosed Appeal Form.

There are Two Kinds of Appeals

Standard Appeal – We will give you a written decision on a standard appeal within **thirty (30) days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We will tell you if we are taking extra time and will explain why more time is needed. If your appeal is for a service you have already received, we will give you a written decision within **sixty (60) days**.

Fast Appeal – We will give you a decision on a fast appeal within **seventy-two (72) hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to **thirty (30) days** for a decision. We will automatically give you a fast appeal if a doctor asks for one for you or if they support your request. If you ask for a fast appeal without support from a doctor, we will decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within **thirty (30) days**.

How to Ask For an Appeal

Step 1: You, your representative, or your Provider and/or Practitioner must ask us for an appeal. You can request an appeal by filling out the enclosed Appeal Form. Your request must include your name, address, Member ID

number, reason you are appealing and any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your Provider and/or Practitioner if you need this information. You can ask for a copy of the medical records, guidelines and other documents we used to make our decision before or during the appeal at no cost to you.

Step 2: Mail, fax, or contact us:

For a Standard Appeal:

Sanford Health Plan, Appeals
PO Box 91110 Sioux Falls, SD 57109-1110
Phone: (877) 652-8544

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal:

Phone: (877) 652-8544 Fax: (605) 312-8910

What Happens Next?

If you ask for an appeal and we continue to deny your request for a service, we will send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Get Help or More Information

- **Sanford Health Plan:** (877) 652-8544
Monday-Friday, 8:00 a.m.-5:00 p.m. CST.
- **Medicare:** (800) 633-4227, 24 hours, 7 days a week. TTY: (877) 486-2048
- **Medicare Rights Center:** (888) 466-9050
- **Elder Care Locator:** (800) 677-1116
- **North Dakota Insurance Department:** (800) 247-0560
- **NDPERS:** (701) 328-3900
- **NDPERS ADA Coordinator:** (701) 328-3900

Medicare Reconsideration Process

If your appeal involves a dispute relates to the payment of services covered solely by Medicare, you must file a Medicare appeal through Medicare, not Sanford Health Plan. The steps to follow in filing a Medicare Reconsideration are explained in the Explanation of Medicare Benefits that you receive from Medicare.

Appeals & Denials Department

Phone: (877) 652-8544

Fax: (605) 312-8910

sanfordhealthplan.com



Appeal Filing 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: _____

Person completing form: Authorized Representative (Family/Caregiver) Provider/Doctor

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Member signature (required): _____

If this appeal is urgent, the Member signature is not required.

Yes No Waiting the routine appeal processing time (14-30 calendar days) could seriously jeopardize the life or health, ability to regain maximum function; or would subject the Member to severe pain that cannot be managed without the service or treatment so this appeal should be processed urgently.

Tell us why you do not agree with this decision. Please include any additional information to help us consider your request:

Send this form and your denial notice to:

Sanford Health Plan, Attention: Appeals

PO Box 91110

Sioux Falls, SD 57109-1110

Phone: (877) 652-8544

Fax: (605) 312-8910

Keep copies of this notice & all other documents related to this request.