Medicare Health Plan Appeal Form and Checklist for Filing a Level III Appeal of prior denial to The Statewide Benefits Office (SBO)

Any Medicare member of the State of Delaware's Group Health Insurance Program may request that the Statewide Benefits Office (SBO) conduct a Level III appeal of the processing of health care provided by Highmark for him/her-self, covered spouse or covered child/ren.

Members of the Highmark Special Medicfill Medicare Supplement Plan should complete and submit this appeal form for denied services that are not covered by Medicare but covered by the Highmark Special Medicfill plan ***only if****:*

1. You have received both Level I and Level II appeal denials from Highmark in writing and it is within 20 days of the postmark date of the notice of the Level II denial, or
2. You received a Level I expedited appeal denial from Highmark in writing and it is within 20 days of the postmark date of the notice of the Level I expedited appeal.

Please visit SBO's website at de.gov/statewidebenefits and review the "Appeal Process" for the Highmark Special Medicfill Medicare Supplement Plan.

To file a Level III appeal in writing to SBO, complete the following checklist items:

□ Indicate which of the above situations apply to your Level III appeal request (1 or2) _______

□ Include copies of your **prior appeal level requests** and the **denial letters from your carrier**.

□ Fill out the following **information**:

Subscriber First Name: _____________________ Last Name: ____________________________

Member First Name: ______________________ Last Name: ____________________________

Member Home Mailing Address/Street: ____

City: _________________________________ State: ___________ Zip Code: _______________

E-mail Address (if applicable): ____

Daytime Telephone Number (between 8:00 A.M. to 4:30 P.M.):

(__________) ___________ - _________________

Subscriber's Pension ID Number ___________________________________

Member ID Number (see Highmark Member ID Card): _______________________________ *OR*

Member Social Security Number: ____________________________________

Concern/Appeal is for services provided to (Fill in the appropriate circle):
O Self O Spouse O Child/ren

If Spouse or Child, provide Spouse or Child's Name and Date of Birth:

First Name: _____________________ Last Name: _________________________________

Date of Birth (MM/DD/YYYY): _________/__________/_____________

□ Complete and include the **State of Delaware Authorization for Release of Protected Health Information Form** on SBO's website at de.gov/statewidebenefits. If appeal is for the member's spouse or child 18 years of age or older, then spouse or child must complete and sign the State of Delaware Authorization for Release Protected Health Information form.

□ As a separate document, provide the **reason for your appeal**. This must include a detailed explanation as to why the denial should be overturned. The explanation should include specifics regarding the benefit your plan provides, what service or coverage was not provided or paid on your behalf according to your plan coverage, and the services for which you are requesting coverage. For example, "My plan states that the Emergency Room (ER) fee will be waived if the patient is admitted to the hospital. On the date in question, I went to the ER, and was admitted to the hospital later that same day. I was charged a copay for the ER visit. I believe it should be waived."

□ Include **medical documentation** relevant to your appeal**:**
- ✓ Physician (office notes), lab, hospital and emergency room records
- ✓ Dates of service, claim numbers and claim amounts
- ✓ Explanation of Benefits (EOBs)
- ✓ Medical necessity approval from physician (this is required for the health plan to cover the cost of services)

Submit all of the items in this checklist/form as one complete packet of information to SBO by fax at 302-739-8339 or by U.S. Mail at:

Appeals Administrator
RE: APPEAL
Statewide Benefits Office
841 Silver Lake Blvd.
Suite 100
Dover, DE 19904

Please note: The Appeals Administrator from SBO (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the employee and his/her health carrier within 30 days of receiving this packet of information.

Have questions or concerns regarding this form?

Contact SBO at 1-800-489-8933