Member Appeal Submission Form

Instructions

Within this form, the terms "you" and "your" refer to the patient or, if applicable, their parent/guardian or authorized representative. The terms "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator.

Please complete this form if you disagree with our decision to deny (whether in whole or in part) or apply any of the following: (1) copayments; (2) deductibles; (3) coinsurance; (4) eligibility; (5) benefits; or (6) pre-authorizations.

Your appeal must include a completed Member Appeal Submission Form (referred to from here forward as "Form") and/or a written statement, signed by you. It must also include (1) all facts and theories supporting your claim for benefits; (2) a statement in clear and concise terms of your reason(s) for disagreement with the handling of the claim; and (3) any material/information that indicates you are entitled to benefits under the Plan. Appeals qualifying as "urgent" may be made verbally by calling us at 800-869-7093 and speaking to a member of the Appeals department.

We must receive this Form within 180 calendar days of the initial adverse benefit determination date. Please be advised that failure to file a timely appeal will bar you from any further review of the initial adverse benefit determination under these procedures or in a court of law.

Your Plan may have specific appeal rights or procedures that differ from those listed herein. Please refer to the appeal provisions within your Summary Plan Description (SPD) for more information.

Average turnaround times for appeal determinations are as follows:

Pre-service[1] Appeals (All Levels)
- Urgent: *72 Hours*
- Standard: *15 Days*

Post-service[2] Appeals
- First and Second Levels: *30 Days*
- Federal External Review: *45 Days*

Submission Information

Please Note: We encourage you to fill out and submit the form electronically. However, if your appeal is urgent (see criteria on page 4), you will need to print the form and have your physician sign it.

Electronic Submission Options

✓ **Option 1: Fill out Online**:
1. Go to accesshma.com and then go to **Download Member Forms**
2. Click on the DocuSign option under **Member Appeal Submission Form**
3. Fill out and submit the Form in DocuSign

✓ **Option 2: Fill out a PDF Form** (not recommended on mobile devices and in Internet browsers):
1. Go to accesshma.com and then go to **Download Member Forms**
2. Click on the PDF option under **Member Appeal Submission Form**
3. Fill out the Form in compatible PDF software like Adobe Reader or Acrobat
4. Email your completed Form to: appeals@accesstpa.com

Paper Submission Options

✓ **Option 1: Fax** the completed Form to: 855-462-8875

✓ **Option 2: Mail** the completed Form to:
HMA
Attn: Appeals Department
PO Box 85016
Bellevue WA 98015-5016

[1] Pre-service: Service has not yet been provided.
[2] Post-service: Service has already been provided.

HMA

Member Appeal Submission Form

Patient Information (Required)

First Name _____ **Last Name** _____

Mailing Address _____

City _____ **State** _____ **ZIP** _____

Phone Number _____ **Member ID Number**[?] _____ **Group Number**[?] _____

Group Name[?] _____

[?] *This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".*

How do you want to be notified of the outcome of your appeal? Pick only one option:

○ **Email** to: _____ ○ **Fax** to: _____ ○ **Mail** to the same address above

○ **Mail** to: **Address** _____

City _____ **State** _____ **ZIP** _____

Authorized Representative Information (Optional)

You may appoint one (1) authorized representative at a time to assist you in appealing an adverse benefit determination. If you appoint an authorized representative, that person shall be authorized to represent you in all matters concerning your appeal. Additionally, references to "Patient" or "covered Plan Participant" in the terms and provisions of the applicable Plan and its Summary Plan Description (SPD) will refer to your authorized representative.

One of the following persons may act as your authorized representative: (1) your treating medical provider, as designated by you on this Form; (2) a person holding your durable power of attorney (POA); (3) if you are incapacitated due to sickness or injury, the person appointed as guardian to have care and custody of you by a court of competent jurisdiction; or (4) an individual designated by you on this Form who is someone other than those previously listed here.

If your authorized representative is an attorney-in-fact under a durable power of attorney, we will send all related correspondence in connection with your appeal, including benefit determinations, to them. Otherwise, we will send all related correspondence, including benefit determinations, to your authorized representative, with copies provided to you upon request.

First Name _____ **Last Name** _____

Relationship to Patient _____

Mailing Address _____

City _____ **State** _____ **ZIP** _____

How do you want to be notified of the outcome of the patient's appeal? Pick only one option:

○ **Email** to: _____ ○ **Fax** to: _____ ○ **Mail** to the same address above

○ **Mail** to: **Address** _____

City _____ **State** _____ **ZIP** _____

HMA

Member Appeal Submission Form

Claim or Pre-authorization Number(s) Being Appealed (Required)

Rationale for Appeal (Required)

Please describe the reason(s) why this benefit denial should be overturned on appeal and include any relevant documentation, such as medical records, chart notes, letter(s) from the treating physician, and so forth. If you are unable to fit all rationale within this box, please attach additional pages as necessary.

Appeal Level[1] (Required)

What is your appeal level? (Pick one)	Has the service in question been provided?	Is this appeal urgent? ("Pre-service" appeals only)
○ First	○ Yes (This is a "Post-service" appeal)	○ Yes (Physician certification needed below)
○ Second	○ No (This is "Pre-service" appeal)	○ No
○ Federal External Review (FER)		

Attachments (Required If Applicable)

Please include all relevant material. Failure to include all necessary material could result in processing delays or appeal denial.

Patient or Parent/Guardian Signature (Required)

Printed Name (First and Last)

Relationship to Patient (If you are the patient, put "Self")

Signature

Date

By signing this Form you attest 1) You are either the patient referenced herein or their parent/guardian; 2) You (the patient) are exercising your appeal rights per the terms and conditions of your Plan; 3) The information listed herein is correct to the best of your knowledge.

[1] Each appeal level requires a separate submission of this Form. In other words, if your first-level appeal is denied, you must submit a new Form if you want to request a second-level appeal; If your second-level appeal is denied, you must submit a new Form if you want to request a Federal External Review. Definitions of each appeal level are as follows:

- **First-level Appeal**: You have not previously submitted an appeal.
- **Second-level Appeal**: You previously submitted an appeal and it was denied.
- **Federal External Review (FER)**: You previously submitted first and second-level appeals and they were both denied.

The following sections are for completion by the physician only if the appeal is urgent.

Urgent Pre-service Appeal Physician Certification (Only Required If Appeal Is Urgent)

In order to qualify as "urgent", the service being requested must meet all of the following criteria:

- The Department of Labor (DOL) definition of "urgent": "…application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the claimant, or the claimant's ability to regain maximum function, or – in the opinion of a physician with knowledge of the claimant's medical condition – would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim."
- The adverse benefit determination must be for services not yet performed ("pre-service").

Note: Scheduling conveniences and constraints do not meet DOL criteria for urgent processing. Standard (non-urgent) pre-service appeal determinations take up to 15 calendar days. If this time period could jeopardize the patient, please call us at 800-869-7093 and speak to someone in the Appeals department.

Physician Contact Information

First Name _____ **Last Name** _____

Phone Number _____ **Extension** _____ **Fax Number** _____

Mailing Address _____

City _____ **State** _____ **ZIP** _____

Physician Office/Staff - Direct Contact Information

First Name _____ **Last Name** _____

Phone Number _____ **Extension** _____ **Fax Number** _____

_____ _____

Physician Signature **Date**

By signing and submitting this Form you attest that you are the patient's attending physician, the service in question meets all criteria above defining "urgent", and that the information listed herein is correct to the best of your knowledge.

Attachments (Required If Applicable)

Please include all relevant material. Failure to include all necessary material could result in processing delays or appeal denial.